

**POLICIES
AND
PROCEDURES
FOR
MONEY FOLLOWS THE PERSON**



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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**POLICY AND PROCEDURES
FOR
MONEY FOLLOWS THE PERSON**

TABLE OF CONTENTS

CHAPTER 600	MONEY FOLLOWS THE PERSON OVERVIEW	I
	Section 600.0	Introduction to MFP, Goals and Objectives
	Section 600.1	MFP Policy & Procedure Manual
	Section 600.2	MFP Project Benchmarks
	Section 600.3	MFP Transition Services
	Section 600.4	MFP Transition Coordinators, Case Expeditors
	Section 600.5	MFP Services and HCBS Waiver Services
	Section 600.6	Authority
	Section 600.7	Structure and Administration
CHAPTER 601	INTEGRATED MFP AND WAIVER PROCESSES	II
	Section 601.0	Introduction To Process Flowcharts
	Section 601.1	Elderly and Disabled Waiver-CCSP Process
	Section 601.2	Elderly and Disabled Waiver-SOURCE Process
	Section 601.3	Independent Care Waiver Process
	Section 601.4	Fiscal Intermediary Reimbursement Process
	Section 601.5	NOW and COMP Waiver Services Process
	Section 601.6	DHS/DBHDD Reimbursement Process
CHAPTER 602	ELIGIBILITY, RECRUITMENT AND ENROLLMENT	III
	Section 602.0	Introduction
	Section 602.1	MFP Eligibility Criteria
	Section 602.2	Outreach, Marketing and Education Strategies
	Section 602.3	Recruiting
	Section 602.4	Participant Consent, Rights and Responsibilities
	Section 602.5	Working with Guardians
	Section 602.6	Screening Potential MFP Participants
	Section 602.7	Referral Sources
	Section 602.8	Quality of Life Survey
	Section 602.9	Waiting List for MFP Services
CHAPTER 603	PARTICIPANT ASSURANCES	IV
	Section 603.0	Introduction
	Section 603.1	Ensuring Health, Safety and Welfare
	Section 603.2	24/7 Emergency Backup Plans
	Section 603.3	Complaints Process and Critical Incident Reports

	Section 603.4	Participant Denial or Termination from MFP	
	Section 603.5	Appeal Process and Administrative Review	
CHAPTER 604	TRANSITION PLANS & AUTHORIZATION FOR SERVICES V		
	Section 604.0	Introduction	
	Section 604.1	Participant-Directed Transition Planning	
	Section 604.2	The Individualized Transition Plan (ITP)	
	Section 604.3	Authorizations for MFP Transition Services	
	Section 604.4	Discharge Day Planning and MFP Lock-in Spans	
	Section 604.5	Changes in Participant Status	
	Section 604.6	Encouraging Self-Direction in Waivers	
	Section 604.7	Standards of Promptness	
CHAPTER 605	HOUSING AND TRANSPORTATION		VI
	Section 605.0	Introduction	
	Section 605.1	Types of Qualified Residences	
	Section 605.2	Housing Search Tools and Strategies	
	Section 605.3	Subsidized and Other Housing Resources	
	Section 605.4	Housing Choice Voucher Programs	
	Section 605.5	Home Modifications	
	Section 605.6	Security and Utility Deposits	
	Section 605.7	Transportation Options	
CHAPTER 606	POST-DISCHARGE FOLLOW-UP & REPORTING		VII
	Section 606.0	Introduction	
	Section 606.1	Using the Fiscal Intermediary	
	Section 606.2	Request for Additional MFP Services	
	Section 606.3	MFP Participant Status Changes	
	Section 606.4	Review of the Individualized Transition Plan	
	Section 606.5	Reporting Requirements	
	Section 606.6	Continuity of Care (day 366 and beyond)	
	Section 606.7	Professional Development Requirements	
CHAPTER 700	SCOPE OF MFP TRANSITION SERVICES		VIII
	Section 701	General	
	Section 702	Exclusions and Special Conditions	
	Section 703	Duplication of Services	
	Section 704	Peer Community Support	
	Section 705	Trial Visits-Personal Support Services	
	Section 706	Household Furnishings	
	Section 707	Household Goods and Supplies	
	Section 708	Moving Expenses	

Section 709	Utility Deposits
Section 710	Security Deposits
Section 711	Roommate Match
Section 712	Transportation
Section 713	Skilled Out-of-Home Respite
Section 714	Caregivers Training
Section 715	Long-Term Care Ombudsman Services
Section 716	Equipment & Supplies
Section 717	Vehicle Adaptations
Section 718	Environmental Modifications

CHAPTER 800 PARTICIPANT RECORDS IX

Section 801	Records Administration
Section 802	Secure File Transfer Protocol for MFP
Section 803	MFP Participant Tracking Database
Section 804	Record-Keeping Processes and Standards

APPENDICES

	APPENDIX A	Documentation & Information for Housing Searches
Rev. 04/10	APPENDIX B	Per- and Post-Transition Services Table
Rev. 07/10	APPENDIX C	Tri-fold Recruiting Brochure
Rev. 01/10	APPENDIX D1	Authorization for Use or Disclosure of Health Information
Rev. 07/10	APPENDIX D2	MFP Consent for Participation
	APPENDIX E	How to Obtain the Booklet, HCBS, A Guide to Medicaid Waiver Programs in Georgia
	APPENDIX F	Area Agency on Aging/AAA Gateway Network
Rev. 07/10	APPENDIX G	MFP Transition Screening Form
Rev. 07/10	APPENDIX H	MFP Recruiting Text
	APPENDIX I	SOURCE Providers
Rev. 07/10	APPENDIX J	Checklist for Transfer to Community Placement
	APPENDIX K	Sample Medicaid Card
Rev. 07/10		

	APPENDIX L	Aging and Disability Resource Connections
	APPENDIX M	(Open)
	APPENDIX N	Non Emergency Transportation Broker System
	APPENDIX O	(Open)
Rev. 01/10	APPENDIX P	Startup Household Goods and Supplies
	APPENDIX Q1	Individualized Transition Plan (ITP)
	APPENDIX Q2	Guidelines for Completing the ITP
Rev. 07/10	APPENDIX R	Discharge Day Checklist
Rev. 04/10	APPENDIX S	Authorization for MFP Services
Rev. 01/10	APPENDIX T	Quote Form for Equipment & Supplies, Environmental Mods and /or Vehicle Adaptations
	APPENDIX U	Vendor Payment Request to TC
Rev. 07/10	APPENDIX V	MFP Vendor Import File
	APPENDIX W1	Transition Document Submission Instructions
Rev. 01/10	APPENDIX W2	Monthly Report of Persons Served, Monthly Report of Completed QoL Surveys, Monthly Update of MFP HVC Program Participation
Rev. 07/10	APPENDIX W3	Quarterly Report of Program Activities
Rev. 01/10	APPENDIX X	Request for Additional MFP Services
	APPENDIX Y	Participant Enrollment Change Form
	APPENDIX Z	Transportation Resources
Rev. 07/10	APPENDIX AA	Referral Letter for Housing Choice Voucher Program
	APPENDIX AB	MFP Sentinel Event Report
Rev. 01/10	APPENDIX AC	Notice of Denial or Termination from MFP
Rev. 07/10	APPENDIX AD	MFP Enrollment End Letter

CHAPTER 600

MONEY FOLLOWS THE PERSON OVERVIEW

600.0 Introduction to MFP, Goals and Objectives

In May 2007, the Centers of Medicare and Medicaid Services (CMS) awarded Georgia the Money Follows the Person (MFP) Rebalancing Demonstration grant established by the Deficit Reduction Act of 2005. Money Follows the Person is a five year demonstration grant awarded to the State of Georgia and is administered by the Department of Community Health (DCH). DCH acts as the overall coordinator for policy and operational issues in a joint effort with the Department of Human Services (DHS). MFP is designed to transition 618 qualified Medicaid members from nursing facilities, hospitals and intermediate care facilities (ICF) to qualified community residences. MFP supplements and expands on current Olmstead Initiative and waiver programs.

Rev. 04/10

Georgia's Olmstead Initiative has evolved over time to identify areas to make quality community services more available and accessible to Georgians with disabilities within the resources available; to call for more consistency in statewide plans for identifying those eligible for and desiring community placement and evaluating their needs for services; and calling for more person-directed planning to closely involve the individual and family in deciding what services are suitable.

Rev. 07/10

To extend and complement the State's Olmstead initiative, MFP provides 365 days of transition services to qualified participants, most of who are enrolled in HCBS waivers. After receiving 365 calendar days of MFP transition services, members will receive all Medicaid Waiver and State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services such as the Social Services Block Grant and the Older Americans Act, and local community funded services.

Goals and Objectives of Georgia's MFP Demonstration

MFP addresses the long-term care needs of three specific populations: older adults, persons with physical disabilities and/or acquired brain injury (ABI) and persons with developmental disabilities or mental retardation. The MFP demonstration builds on and supplements services in the current 1915c waivers that serve the above populations, including:

1. The Community Care Services Program (CCSP)

The Community Care Services Program (CCSP) provides home and community-based waiver services to older adults who are functionally impaired or have disabilities. These individuals are also referred as the Aged, Blind, or Disabled. CCSP helps eligible recipients (older adults and/or persons with physical disabilities) return to the community from

nursing homes or remain in their own home, the homes of caregivers or in other community settings as long as possible.

2. The Service Options Using Resources in a Community Environment (SOURCE)

SOURCE (Service Options Using Resources in a Community Environment) is a statewide Primary Care Enhanced Case Management Service that links primary medical care with many long-term health services in a person's home or community setting to prevent unnecessary emergency room visits and hospital and nursing facility stays. SOURCE helps eligible recipients (older adults and/or persons with physical disabilities) remain in their own home, the homes of caregivers or in other community settings as long as possible.

3. The Independent Care Waiver Program (ICWP)

The Independent Care Waiver Program (ICWP) allows the Department of Community Health to provide services for adult individuals between the ages of 21 and 64 with physical disabilities or traumatic brain injuries that will help them live in their own homes and communities as an alternative to a nursing facility. Individuals served by the program are required to meet the same level of care for admission to a hospital or nursing facility and be Medicaid eligible or potentially Medicaid eligible.

4. The New Options Waiver (NOW) Comprehensive Wavier (COMP) Programs

The New Options Waiver (NOW) and Comprehensive Waiver (COMP) programs provide HCBS waiver services to persons with developmental disabilities. Services are provided to eligible individuals who reside in or are at risk of institutional placement.

To accommodate qualified MFP participants, the CCSP, ICWP, and NOW and COMP waivers have submitted appropriation requests for additional waiver slots for MFP participants each year. For MFP participants entering the NOW and COMP waivers, the efforts of case expeditors and support coordinators will be supplemented, under the DCH/DBHDD Interagency Agreement, to enable the State to transition persons out of ICFs into the NOW and COMP waivers.

DCH has a contract in place with a private vendor to perform transition screenings to identify qualified participants who may wish to transition out of institutions and into CCSP, SOURCE, or ICWP waiver programs.

MFP addresses the four demonstration objectives outlined in the Deficit Reduction Act of 2005:

Objective 1: To increase the use of home and community-based, rather than institutional, long-term care services.

In an effort to provide additional alternatives to institutional stays, MFP will utilize Home and Community Based Waiver Services (HCBS) coupled with MFP transition services to resettle Medicaid eligible, qualified individuals currently residing in an institutional setting for a minimum of 90 days. There are some limitations to the 90 day eligibility policy--short-term rehabilitation stays of 90 days or less will not count toward meeting MFP eligibility criteria. For example, if an individual enters a nursing facility for 90 days of rehabilitation following surgery, and the stay is not intended to be a long-term, the 90 day stay will not count toward MFP eligibility. If the stay is longer than 90 days, the remainder of the stay after 90 days may be counted toward MFP eligibility.

Once transitioned, participants will receive HCBS waiver services as long as they meet waiver Level of Care criteria. Participants will receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, State funded programs and local community funded services.

Through marketing, development of supportive peer networks and identifying individuals who prefer to transition to community settings, the State will move toward rebalanced spending in favor of home and community-based services and supports. Over the period of the grant, the State will:

- Transition 618 persons to community settings,
- By 2011, increase federal and state expenditures on HCBS by over \$36 million,
- Expand DCH long-term care budget to 40.2% for HCBS compared to the 30.3% spent in FY 2005, and
- Use the enhanced Federal Medical Assistance Percentage (FMAP) rate to reinvest savings realized by the State into the MFP Demonstration, infrastructure to support the MFP Demonstration and transition services.

Georgia's stakeholders are committed to redirecting nursing facilities' and intermediate care facilities' excess capacity to alternative uses. For example, MFP will work with the Georgia Health Care Association to develop strategies to re-deploy existing nursing facility capacity for other purposes (e.g. skilled respite services and/or adult day health).

Objective 2: To eliminate barriers and mechanisms, whether in State law, State Medicaid Plan, State budgets, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in setting of their choice.

MFP stakeholders identified numerous barriers to effective systems for resettlement and explored ways to eliminate these barriers to transitioning to the community from institutions. Chief among the identified barriers were:

- Lack of available, affordable, accessible and integrated housing and rental subsidies for participants with limited income and no community supports,
- Lack of financial resources for one-time expenditures needed to transition,
- “Fear of the unknowns” associated with relocation,
- Lack of a coordinating system for planning and service delivery among State, regional and local entities, and
- Lack of a unified information and referral system to all waivers that linked interested participants to services and resources needed for transition.

MFP funding supports a broad range of transition services, including resettlement assistance, through local peer support networks that assist participants/members with community knowledge, experience and local resources. The MFP Housing workgroup has developed opportunities and resources to assist MFP participants with housing options and increasing the State’s ability to address long and short term goals for expanding State’s supply of affordable, accessible and integrated housing.

MFP is funding transition services (see *Appendix B: MFP Transition Services Table*) to help people resettle in the community. MFP will enhance current systems for accessing information and services by incorporating a Team Training Process so that MFP Transition Coordinators and Peer Supporters receive training with case managers. Using a team approach will improve current coordination between systems.

MFP is developing a collaborative resource network by building on the Area Agency on Aging-AAA/Gateway Network, the Georgia Centers for Independent Living, the Aging and Disability Resource Connections (ADRC) network, Long Term Care Ombudsmen and the DBHDD Regional Network and other service points. The collaborative resource network will result in a transparent, easily accessible and open system for obtaining services, long-term care information and resources, knowledge of where to go for assistance and how to obtain basic information. These processes will strengthen the coordinating systems for planning and service delivery and unify referral processes across all waivers.

Objective 3: To increase the ability of the State Medicaid Program to assure continued provision of home and community-based long-term services to eligible individuals who choose to transition from an institution to a community setting.

An individual eligible for MFP will not be referred to a waiver program waiting list unless the number of qualified MFP candidates exceeds the reserved capacity of the waiver. Through reserved capacity (i.e. slots) in the CCSP, SOURCE, ICWP, NOW and COMP waiver programs, the State will assure that transitioning participants enter these waivers immediately upon discharge from the institution. Services will continue to transitioned individuals beyond the demonstration

period. Transitioned individuals will enter an appropriate HCBS waiver program and receive services as long as they meet the institutional level of care criteria for services offered in those waivers. At any point that they no longer meet waiver criteria, participants will be assisted in transitioning to non-Medicaid State and community resources as their needs require.

Objective 4: Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long term care services and to provide for continuous quality improvement in such services.

MFP participants will be afforded the same level of safeguards as those available to participants enrolled in existing waivers, as described in 1915c waiver Appendix H; CCSP, SOURCE, ICWP, NOW and COMP. Through an ongoing process of discovery, remediation and improvement, the Department of Community Health (DCH) assures that each waiver provides for a Quality Management Strategy (QMS). DCH assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. DCH continues to implement and improve the Quality Management Strategy for each waiver as specified in 1915c Appendix H.

600.1 The MFP Policy & Procedure Manual

The MFP Policy and Procedures Manual contains a Table of Contents, chapters, sub-sections and appendices. After the Introduction, Benchmarks, Structure and Administration, MFP partners are identified and roles are described. A description of MFP transition services is followed by an identification of the legislative/policy authority for the Demonstration. The chapters that follow are identified in the order that represents the flow of a participant entering MFP from referral through continuity of care post demonstration.

Chapters and sub-sections are numbered for easy referencing. Each section gives information about a particular topic. For example, this Section 600.1 contains information on the arrangement of information in the MFP Policy and Procedure Manual. The appendices are generally arranged to match the flow of participant processes. For example, *Appendix A, Transition Checklist for Transfer to Community Placement*, is a tool used by MFP TCs to track the tasks and responsibilities of the MFP transition team assisting the MFP participant. *Appendix A* precedes *Appendix B, MFP Transition Services Table*. Acronyms and abbreviations are alphabetically listed.

The manual is written as if the MFP Transition Coordinator (TC) is the reader. The structure of each chapter and section is consistent and includes policy statements, topics, procedures, guidance, documentation and references. Policy Statements are brief definition or statements of the policy which governs a topic.

Procedures provide instructions to TCs for implementing policies. Further Guidance sections contain specific examples of how the TC is to apply the policy, under specific conditions (who, specific conditions and how). The Reference statement tells the reader where to find related information. References are used to avoid duplicating text contained in other sections and chapters of The MFP Policy & Procedures Manual. Subheadings accompany lengthy narratives for easy reference. Vertical lists use bullets when actions occur in no prescribed order. If actions occur in a specific sequence, lists are numbered to identify the sequence. The terms FOR FURTHER GUIDANCE, NOTE or EXCEPTION identify information that merits special attention.

The complete name of an abbreviation or acronym is written in the first use in each section; thereafter in the section, the acronym or abbreviation is used.

EXCEPTION: Because of the frequent use of abbreviations and acronyms listed below, they are written only once per section:

AAA	Area Agency on Aging
ABI	Acquired Brain Injury
ADRC	Aging and Disability Resource Connections
CCSP	Community Care Services Program, waiver services
CIL	Center for Independent Living
CM	Case Manager (refers to case managers, care coordinators, and support coordinators)
CMS	Centers for Medicare and Medicaid Services
DAS	Division of Aging Services within DHS
DBHDD	Division of Behavioral Health and Developmental Disabilities
DCH	Department of Community Health
DHS	Department of Human Services
DFCS	Division or Department of Family and Children Services
DRA	Deficit Reduction Act of 2005
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community Based Services
ICF	Intermediate Care Facility
ICWP	Independent Care Waiver Program
ITP	Individualized Transition Plan
MAO/PMAO	Medical Assistance Only/Potential Medical Assistance Only
MDS	Minimum Data Set
MFP	Money Follows the Person Demonstration Project
PSS	Personal Support Services
SILC	State Independent Living Council
SOURCE	Service Options Using Resources in Community Environment

Rev. 07/10

Rev. 07/10

In addition to those conditions for participation in the Medicaid Program which are outlined in Part I Policies and Procedures for Medicaid/PeachCare for Kids Manual applicable to all Medicaid Providers, Money Follows the Person (MFP) providers must adhere to the policies and procedures in this manual and to all

applicable Standards.

600.2 MFP Project Benchmarks

MFP will measure the progress of five benchmarks, two specifically required by CMS and three required by DCH. Stakeholders identified these benchmarks to focus on lasting improvements and enhancements to the home and community based long-term care system to enable money to follow the person from the institution into the community. Continuous reviews, participant assessments, surveys, data collection, community reviews and stakeholder input will provide feedback about progress toward meeting the benchmarks and the services being provided. This feedback will be used to continuously adjust project activities to assure that the benchmarks and stakeholder interests are met.

The two required CMS benchmarks are:

Rev. 04/10

1. The projected numbers of eligible individuals in each target group who will be assisted in transitioning each fiscal year of the demonstration:

MFP will transition 618 consumers from institutional care to community-based settings. Focus will be placed on three specific populations:

- older adults
- participants with developmental disabilities
- participants with physical disabilities/ABI

Table 600.2.1 MFP Transitions by Target Group

CY	Older Adults	DD	Physical Disability/ABI	Totals
2008	2	20	1	23
2009	42	110	43	195
2010	30	110	60	200
2011	30	110	60	200
Totals	104	350	164	618

*NOTE: Throughout the MFP Policy & Procedures Manual, older adults enter either of the Elderly and Disabled Waivers (CCSP or SOURCE) or ICWP. Persons with physical disabilities and/or ABI, can enter either CCSP, SOURCE, or the Independent Care Waiver (if they are between the ages of 21 and 64), depending on need and the availability of waiver slots. Persons with developmental disabilities enter the NOW and COMP

Waiver Programs.

Rev. 04/10

2. Increasing HCBS expenditures relative to institutional long-term expenditures under Medicaid for each year of MFP.

MFP will increase the HCBS expenditures under Medicaid each year of the demonstration program by transitioning individuals out of nursing homes and Intermediate Care Facilities (ICFs).

As indicated in the table below:

- projected increases in Medicaid HCBS spending for all HCBS populations served over the next four years
- anticipated overall expenditure increase, during MFP, in all of the community based programs by over \$36 million, by 2011.
- enhanced FMAP used to reinvest funds in MFP services during the demonstration years.

Table 600.2.2 Total Georgia Medicaid HCBS Spending

FFY	HCBS Expenditures for all non-MFP Medicaid beneficiaries	MFP HCBS Expenditures	Total HCBS Spending (Sum of MFP & non-MFP spending)	Annual Percent age Growth
2006 Actual	\$602,948,440.00	0	\$602,948,440.02	NA
2007 Actual	\$673,897,224.00	\$17,195	\$673,914,419.00	11.77%
2008 Actual/Est.	\$804,687,940.09	\$1,444,617	\$806,132,557.09	19.62%
2009 Estimated	\$885,210,031.95	\$9,390,346	\$894,600,377.95	10.97%
2010 Estimated	\$928,470,531.65	\$12,610,331	\$941,080,862.65	5.2%
2011 Estimated	\$975,944,058.23	\$13,003,274	\$988,947,332.23	5.09%
Totals	\$4,871,158,225.92	\$36,465,763	\$4,907,623,988.92	

Additional three benchmarks that have been selected by stakeholders

Rev. 04/10

3. Improving Processes for Screening, Identifying and Assessing Candidates for Transitioning to increase the rate of successful transitions by 5% each year of the demonstration.

This benchmark sets up indicators that measure the performance of Georgia’s system for transitioning participants. These indicators are designed to track and measure outputs and outcomes of screening, assessment and successful resettlement in the community, based on the current system in place as compared to the MFP system. To the best of our knowledge, no such effort to track the performance of Georgia’s transition system has been undertaken. Because this is ‘new territory,’ there may be a need to adjust the performance indicators as more is known about the utility of the indicator and how the indicator can be tracked.

For the purpose of this benchmark, a successful transition is considered to be (1) a Medicaid eligible older adult or person with a disability, (2) who

needs HCBS services to reside in the community, (3) who transitions to a qualified community-based residence and (4) who resettles in the community for a minimum of six months, with or without interruptions in that period due to short-term institutional admissions. As funds are realized by the state based on the enhanced FMAP, these funds will be used to develop and refine a transition tracking system. The following lists several performance indicators that can be tracked for each system (current and MFP):

- Number of completed transition screenings
- Number of completed Individualized Transition Plans/Person Centered Descriptions
- Number of qualified persons entering home and community services
- Number of successful transitions (six months in community)
- Number of fully completed transitions (365 days in the community)
- Others as indicated

A tracking system has been developed (see *Appendix Z: MFP Manual Tracking Database Screens*) to track successful transitions. Key HCBS stakeholders from DCH, DHS, and DBHDD and key internal and external stakeholders from HCBS initiatives including MFP, Olmstead and the Nursing Home Diversion project participated in the development. The manual tracking database will be used to collect and analyze data with the first MFP screenings in September 2008.

The MFP demonstration enables Georgia to enhance its transition system through funding for Transition Coordinators and transition services. Under the transition program in place prior to MFP, the state had contracted with a private vendor to screen likely candidates for transitioning from nursing facilities. Potential candidates were identified through the use of the Minimum Data Set (MDS). The screening and assessment process included an interview to explain the transition process and provide information on home and community based services.

This early attempt at a transition system will be compared to the new MFP transition process. Performance data will be collected, analyzed, trended and reported to the MFP TouchPoint Project Management meeting beginning in January 2009. The following tables illustrate how the early attempt to track transitions and MFP transition tracking system track performance data. The data used in the tables is projected because data will not be collected until September 1, 2008. Numbers beginning in CY2010 represent a slight increase over CY2009. The numbers are projected based on MFP Benchmark #1 and will be corrected as real data becomes available.

Table 600.2.3 Previous Transition System

System Outputs	CY2008	CY2009	CY2010	CY2011
-Completed transition screenings	NA	NA	NA	NA
-Completed Individualized Transition Plans or Person Centered Descriptions	NA	NA	NA	NA
-Persons entering home and community services	NA	NA	NA	NA
System Outcome				
-Resettled for 6 months	NA	NA	NA	NA
-Completed 365 days of MFP	NA	NA	NA	NA

Table 600.2.4 MFP Transition System

	Actual CY2008	Actual CY2009	Projected CY2010	Projected CY2011
System Outputs				
-Completed transition screenings	60	358	375	375
-Completed Individualized Transition Plans or Person Centered Descriptions	52	193	250	250
-Persons entering home and community services	22	197	200	200
System Outcome				
-Resettled for 6 months	0	99	95%	95%
Completed 365 days of MFP	0	22	90%	90%

Comparison of the current and MFP transition systems will allow for analysis and reporting on the performance of the systems. For example, the tracking system will be used to measure how much of each of the outputs is needed to produce one successful transition. In other words, once data is collected for each output indicator for a calendar year and the number of successfully resettled participants is known for that calendar year, analysis of output indicators will reveal how many of each were needed to produce one successful outcome under each system—a resettlement of at least 6 months. Once this is known, system outputs can be adjusted to produce desired outcomes.

Rev. 04/10

4. Increase HCBS expenditures relative to institutional long-term expenditures under Medicaid for each year MFP.

MFP increases the HCBS expenditures under Medicaid each year of the demonstration program versus institutional long-term care by transitioning individuals out of nursing homes and Intermediate Care Facilities (ICF).

As indicated in the table below:

- Anticipated expenditure increases, from 2005, in all of the community based programs by over \$392 million by 2011.
- Increases in the long-term care budget to 40.2% for HCBS compared to the 30.3% spent in FY 2005.

Table 600.2.5 Long-Term Care Services- Rebalancing Process

Fiscal Year	LTC Institutional Expenditures	%	HCBS Expenditures	%
2005 Actual	\$1,340,391,812	69.7%	\$583,053,980.02	30.3%
2006 Actual	\$1,346,965,550	69.1%	\$602,948,440.00	30.9%
2007 Actual	\$1,251,368,659	65.0%	\$673,914,419.00	35.0%
2008 Actual/Est.	\$1,283,614,256	61.4%	\$806,132,557.09	38.6%
2009 Estimated	\$1,386,031,643	60.8%	\$894,300,377.95	39.2%
2010 Estimated	\$1,427,709,804	60.3%	\$941,080,862.65	39.7%
2011 Estimated	\$1,470,636,931	59.8%	\$988,947,332.23	40.2%

5. Increase opportunities for self (participant)-directed care in all HCBS waivers by 5% per year during each of the demonstration years.

HCBS waiver participants have the option to self-direct Personal Support Services (PSS). MFP will build on these efforts with enhanced outreach, marketing and education opportunities about self-direction of services to candidates for transitioning. This benchmark reflects a commitment to increasing consumers’ knowledge, understanding and utilization of self-directed services.

Self-directed options are available to older adults, participants with physical disabilities and those with developmental disabilities:

- The CCSP waiver offers self-directed Personal Support Services/ Personal Support Extended and Financial Support Services options.
- Independent Care Waiver Program has Consumer-Directed Personal Support Services and Financial Support Services as an optional service delivery mechanism for persons age 21-64 with physical disabilities or ABI.
- NOW and COMP waivers offer Natural Support Enhancement Services (NSEs) as a self-directed alternative to provider managed service delivery options.

The goal of MFP is to expand understanding and awareness for Medicaid eligible persons to self-direct services, increasing the number of persons choosing self-directed option by 5% per year. Data in the table below is projected based current self-direction (CY 2008).

Table 600.2.6 Self-Direction by Waiver

Calendar Year	Elderly & Disabled Waiver	NOW/COM P	ICWP	Totals
CY2008	70	145	52	267
CY2009	74	153	55	282
CY2010	78	161	58	297
CY2011	82	169	61	312

600.3 MFP Transition Services

MFP offers demonstration and transition services to qualified MFP eligible participants. MFP uses HCBS based Medicaid waiver services and “one-time” transition services to help people resettle in the community. See Chapter 700 in this Manual for a more complete description of each of the MFP Transition Services. In addition to HCBS core wavier services, MFP participants may qualify for the following transition services to assist them to move back into the community:

Rev. 07/10

- **Peer Community Support-** This service provides assistance to participants to locate and obtain services, identify and use community resource networks and build connections to individuals and associations in their local community.
- **Trial Visits with Personal Support Services/PCH-** This service provides a brief period of personal support services or a brief stay in a personal care home during a trial visit to the community before transitioning. The purpose of this service is to give the participant an opportunity to manage and direct Personal Support Services (PSS) staff and/or interact with staff in the personal care home.
- **Household Furnishings-** This service provides assistance to participants requiring basic household furnishings (e.g., bed, table, but not limited to items listed) to help participants transition back into the community. This service is intended to help the participant with the initial set-up of a new qualified residence.
- **Household Goods and Supplies-** This service provides assistance to participants requiring basic household goods (e.g., cookware, toiletries). This service is intended to help the participant with the initial set-up of their qualified residence. This service may include a one-time purchase of groceries (up to \$200) to assist a participant with setting up their qualified residence.
- **Moving Expenses-** This service includes the rental of a truck and staff or a moving or delivery service to move the participant’s goods into a community setting. This service is intended to help the participant with the initial set-up of their qualified residence.
- **Utility Deposits-** To assist participants with utility deposits to help

consumers transition back into the community.

- **Security Deposits-** To assist participants with housing application fees and deposits to help consumers transition back into the community
- **Transition Support-** This service provides assistance to help participants with unique service needs during transition (obtaining documentation, accessing paid roommate match services, etc.). This service is intended to support transition only, and will be authorized on a case-by-case basis.
- **Transportation-** This service will enable participants to gain access to community services and resources required for transition (such as searching for housing or obtaining documents). This is provided as a service when transportation is not otherwise available. This service does not replace the Medicaid non-emergency transportation or emergency ambulance services.
- **Community Transition Financial Services-** To provide financial service for payments for the MFP transition services to participants enrolled in the demonstration project.
- **Skilled Out-of-Home Respite-** This service provides brief period of support or relief for caregivers or family members caring for an elderly or disabled individual. This service will pay for up to 14 days during the MFP 365 day demonstration. The respite is done at a Georgia qualified nursing facility or community respite provider approved through a Georgia waiver program.
- **Caregiver Training-** Services to provide training and education to individuals who support or provide companionship or supervision to participants. This service is not provided in order to train paid caregivers.
- **Long-Term Care Ombudsman (LTCO) -** This service provides a periodic contact for review of transitioned participants' health and safety and adjustment in the community - limited to participants in CCSP, SOURCE and ICWP only. Contacts are made monthly, either in person or by telephone for individuals living in community settings other than personal care homes and community living arrangements (LTCO services to PCH and CLA residents remain consistent with service standards regardless of whether an MFP participant resides in the home).
- **Equipment and Supplies** This service can provide equipment that is not otherwise covered by Medicaid. It might include certain types of assistive technology and services, bath chairs, communication systems, or customized molded chair seats to enable individuals to interact more independently, enhancing their quality of life and reducing their dependence.
- **Vehicle Adaptations-** This service enables individuals to interact more independently, enhancing their quality of life and reducing their dependence. This service is limited to participant's or his or her family's

privately owned vehicle and may include such things as a hydraulic lift, a ramps, special seats and other interior modifications for access into and out of the vehicle as well as to improve safety while moving.

- **Environmental Modifications-** This service provides assistance to participants requiring physical adaptations to their qualified residence, or to participants in the Housing Choice Voucher program or community homes on a case-by-case basis. This service could pay for such things as ramps, widening of doorways, grab-bars and bathroom modifications, to ensure participants' health, welfare and safety and to assist participants with their ADLs.

600.4 MFP Transition Coordinators (TC)

Competencies

Transition Coordinators (TCs) receive initial training prior to beginning transitioning work with participants. The MFP Outreach, Marketing and Training Workgroup developed training curriculum and training sessions for Core and Related/Supplemental training for TCs. For more information on professional development and training requirements for TCs, see Chapter 606.7 in this Manual. Training was developed based on the following:

- Scope and benchmarks of the MFP demonstration,
- Independent living philosophy and participant choice counseling,
- MFP eligibility criteria, MFP screening tools,
- Informed consent, complaint processes and critical incident reporting,
- HIPAA and PHI processes and requirements for securing documentation,
- Eligibility criteria for HCBS waivers and State Plan services,
- HCBS waivers, service options, participant-directed service options,
- Tools for identifying affordable, accessible and integrated housing and developing relationships with community housing providers,
- Working with Point-of-Entry systems-- Area Agencies on Aging Area (AAA/Gateway), Aging and Disability Resource Connections (ADRCs), Centers for Independent Living (CILs), Regional Offices of the Department of Behavioral Health and Developmental Disabilities,
- Access to advocacy systems such as Long-Term Care Ombudsmen
- Regional community resources by disability population,
- Involving guardians and persons who have durable power of attorney,
- Transportation options,
- Person-directed planning and circle-of-friends,

Rev. 07/10

- Working with waiver case managers and other professionals and advocates working on resettlement,
- Authorizing MFP pre and post-transition service expenditures, reporting and documentation,
- Procurement of specialized medical equipment and assistive technology for independent living,
- Post-discharge follow-up and conducting the Quality of Life survey, and
- MFP reporting and documentation requirements.

MFP TC Roles and Responsibilities

TC roles and responsibilities include:

- Offer statewide transition services to older adults, participants with mental retardation and /or developmental disabilities and those with physical disabilities/ABI.
- Attend DCH mandated trainings to gain awareness and knowledge about MFP eligibility, MFP demonstration services, home community-based waiver options, other community and regional resources, principles of independent living, participant-directed care and person-directed planning,
- Attend trainings with the HCBS case managers, DHS/Division of Aging Services (DAS) and DBHDD, Area Agencies on Aging Area (AAAs), Aging & Disability Resource Centers (ADRCs) and Georgia's Centers for Independent Living (CILs) and Statewide Independent Living Council (SILC).
- Obtain referrals of potential transitioning candidates from a variety of referral sources to including, but not be limited to, institutional staff, Long Term Care Ombudsmen, point-of-entry systems, consumers and families and from the DBHDD transition team for DD population.
- Distribute outreach, marketing and educational materials to the community, participants and families/friends, regarding the MFP and HCBS waiver programs. Review material with participants/family members and assist with understanding available options during face-to-face interviews.
- Obtain signed informed consent and release of information (see *Appendix D1 Authorization For Use or Disclosure of Health Information and Appendix D2 MFP Consent for Participation*) from institutional residents (or guardian, as appropriate) to participate in MFP. The consent and authorization indicate the choices of the individual and provides access to all institutional records.
- Using the *MFP Transition Screening Form* (see *Appendix G*), screen and conduct face-to-face interviews with members, family/support networks and facility discharge planners (Social Workers and/or Administrators),

Rev. 07/10

Ombudsmen (attendance based on member's approval) to explain the transition process and assess if the individual is interested in leaving the nursing facility or ICF. Build a personal profile of the participant, including gathering medical, financial data, functional and psychosocial information, members' needs for pre and post-transition services, housing, transportation and other community services necessary to re-establish a community-based qualified residence.

- Assist participants to secure personal identification documents.
- Assist participants to complete a waiver referral, follow-up with waiver case managers for approval.
- Assist with the development of the participant's circle-of-friends/support. Facilitate person-centered planning and complete the Individualized Transition Plan (ITP) (see *Appendix Q1 and Q2*). Follow-up with members of the transition team to ensure all assigned task are completed.
- Assist participants to use strategies to locate and secure qualified housing, including the identification of affordable housing options, income-based public and private subsidized housing and rental assistance vouchers (where and when available),
- Assist participants to identify, locate and utilize transportation options,
- Authorize all MFP pre- and post-transition services and track expenditures for participants in coordination with the MFP Fiscal Intermediary and DCH, and maintain accountability and documentation of activities, limitation and caps, and supply documentation to MFP project staff as requested
- Contact appropriate county Department of Family and Children's Services (DFCS) to change the participant's eligibility from nursing facility/institutional to community based
- Assist participants with financial planning for resettlement, including developing and using a budget, money management strategies/financial planning, setting up banking and redirecting Social Security checks from the institution to the participant's/guardian's bank account.
- Facilitate financial arrangements for the procurement of pre- and post-transition services
- Approve invoices for MFP services; submit invoices for payment to FI.
- Arrange for the *Quality of Life* (QoL) survey to be completed 30 days to two weeks prior to discharge and arrange for the surveyor to conduct the QoL Survey at 11 months post community placement.
- Complete the *Discharge Day Checklist* (see *Appendix R*) and make follow-up contact with the participant during the first week and at 30 calendar days post community placement and with the follow-up monthly contact during the MFP period

Rev. 07/10

Rev. 07/10

- Conduct scheduled follow-up with participants; maintain records on all MFP participants interviewed and transitioned; report changes in participant status.
- Submit reports and completed documentation as requested by MFP project staff.
- Successfully transition targeted numbers by population.
- Facilitate on-going communication with waiver case managers.

600.5 MFP Transition Services and HCBS Waiver Services

MFP uses the Medicaid HCBS waiver services and MFP transition services to help people resettle in the community. Current HCBS waivers include the Community Care Services Program, SOURCE, the Independent Care Waiver Program (ICWP) and the NOW and COMP Waiver Programs. This section identifies procedures for service delivery for each population that will be served through MFP and mechanisms in place to ensure that participants remain eligible for Medicaid HCBS waivers after the 365 day MFP period. Populations targeted include qualified Medicaid recipients who have resided in an institutional setting (i.e. nursing home, ICFs) for a period of at least ninety (90) days and who have expressed interest in resettlement. There is a limitation to the 90 day eligibility policy--short-term rehabilitation stays of 90 days do not count toward meeting MFP eligibility criteria. For example, if an individual enters a nursing facility for 90 days of rehabilitation following surgery, and the stay is not intended to be a long-term, the stay will not count toward MFP eligibility. If the stay is longer than 90 days, the remainder of the stay after 90 days may be counted toward MFP eligibility. Current HCBS waivers serve older adults, adults and children with physical disabilities, persons with acquired brain injury, and persons with developmental disabilities.

Rev. 07/10

TCs provide, or arrange for, a wrap-around set of transition services to prepare the MFP participant to transition and work with waiver case managers to ensure adequacy of services and supports and participant satisfaction. TC activities include responsibility for assembling and facilitating the transition team for each participant, coordinating the array of pre- and post-transition services and providers that will be needed on or shortly after the move to the community, and arranging the time-sensitive transition services that are needed in order for the participant to resettle, including referrals for waiver assessments and supporting the participant in identifying a personal support network.

For MFP participants, person-directed planning and self-directed services are the cornerstones of transition. TCs use the MFP Screening Tool to gather information about participants' goals, service needs and information for discussion with the appropriate waiver case manager. Each HCBS waiver uses a different assessment tool to determine waiver eligibility and to plan for services

and supports. Not only do TCs arrange for a set of wrap-around MFP services, they are responsible for coordinating with waiver case managers to ensure that waiver assessments are completed, that waiver services are adequate and that the MFP participant is satisfied and continues the community placement after the 365 days of MFP.

Transitioned participants will receive HCBS waiver services as long as they meet waiver criteria. Participants will receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, state funded programs, and local community support system funded services. **Table 600.5.1** provides a summary of these services.

Home and Community Based Services for Older Adults

The Elderly and Disabled Waiver programs (CCSP and SOURCE) offer a variety of services as an alternative to institutional care as indicated on **Table 600.5.1** that follows. A system of coordinated community care and support services assists the older adult MFP participant to live in their own home or with families in the community. These waivers promote independence and freedom of choice. Participant-directed service options are available or members may opt for traditional service delivery.

Home and Community Based Services for Persons with Physical Disabilities/ABI

The ICWP waiver program offers a variety of services as an alternative to institutional care as indicated on **Table 600.5.1** below. In addition to the core services, ICWP covers specialized medical equipment and supplies, counseling and home modification. ICWP does not pay for room and board. The applicant, the case manager, and the applicant's family and/or friends work together as a planning team to establish a service plan. The plan describes the applicant's present circumstances, strengths, needs, the services required, a listing of the providers selected and projected budget.

Home and Community Based Services for Persons with Developmental Disabilities

Two HCBS waivers for persons with DD provide for the inclusion of supports needed beyond the transition process – the New Options Waiver (NOW) and the Comprehensive (COMP) waiver. The NOW and COMP waivers will make available a wide range of quality of care and quality of life services that are sufficiently flexible to allow customization based on personal needs and preferences as outline on **Table 600.5.1**. These include traditional agency directed services as well as self-directed services.

Table 600.5.1 Benefits and Services for MFP Participants by Waiver

<i>Elderly/Disabled Waivers (CCSP/SOURCE)</i>	<i>Independent Care Waiver Program (ICWP)</i>	<i>New Options Waiver (NOW)</i>	<i>Comprehensive Waiver (COMP)</i>
➤ Adult Day Health	➤ Adult Day Care	➤ Adult Occupational Therapy Svs	➤ Adult Occupational Therapy Svs
➤ Alternative Living Services	➤ Behavior Management	➤ Adult Physical Therapy Services	➤ Adult Physical Therapy Services
➤ Emergency Response Services	➤ Case Management	➤ Adult Speech and Language Therapy Services	➤ Adult Speech and Language Therapy Services
➤ Enhanced Case Management	➤ Consumer-Directed PSS	➤ Behavioral Supports Consultation	➤ Behavioral Supports Consultation
➤ Financial Management Services	➤ Counseling	➤ Community Access	➤ Community Access
➤ Home Delivered Meals	➤ Enhanced Case Management	➤ Community Guide	➤ Community Guide
➤ Home Delivered Services	➤ Environment Modification	➤ Community Living Support	➤ Community Living Support
➤ Out-of-Home Respite	➤ Fiscal Intermediary	➤ Environmental Access Adaptation	➤ Community Residential Alternative
➤ Personal Support Services (PSS)/(PSSX)/ Consumer Directed	➤ Personal Emergency Monitoring	➤ Financial Support Services	➤ Environmental Access Adaptation
➤ Skilled Nursing Services	➤ Personal Emergency Response	➤ Individual Directed Goods and Svs	➤ Financial Support Services
	➤ Personal Emergency Response Installation	➤ Natural Support Training	➤ Prevocational Services
	➤ Personal Support Services	➤ Prevocational Services	➤ Specialized Medical Equipment
	➤ Respite Services	➤ Respite Services	➤ Specialized Medical Supplies
	➤ Skilled Nursing	➤ Specialized Medical Equipment	➤ Support Coordination
	➤ Specialized Medical Equipment and Supplies	➤ Specialized Medical Supplies	➤ Supported Employment
	➤ Vehicle Adaptation	➤ Support Coordination	➤ Transportation
		➤ Supported Employment	➤ Vehicle Adaptation
		➤ Transportation	
		➤ Vehicle Adaptation	
<i>Other Non-Medicaid Services</i>			
➤ Adult Protective Services	➤ Adult Protective Services	➤ Adult Protective Services	➤ Adult Protective Services
➤ Caregiver Supports	➤ Social Services Block Grant Svs	➤ State Funded Services	➤ State Funded Services
➤ Older Americans Act Services	➤ State Funded Services		
➤ Social Services Block Grant Svs			
➤ State Funded Services			

600.6 Authority

The Federal 2005 Deficit Reduction Act (DRA) established funding for the Money Follows the Person Demonstration. The following section reproduces the section from the Federal Register in its entirety for reference.

SEC. 6071. <<NOTE: Grants. 42 USC 1396a note.>> MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) Program Purpose and Authority.--The Secretary is authorized to award, on a competitive basis, grants to States in accordance with this section for demonstration projects (each in this section referred to as an ``MFP demonstration project'') designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under State Medicaid programs:

(1) Rebalancing.--Increase the use of home and community-based, rather than institutional, long-term care services.

(2) Money follows the person.--Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

(3) Continuity of service.--Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.

(4) Quality assurance and quality improvement.--Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

(b) Definitions.--For purposes of this section:

(1) Home and community-based long-term care services.--The term ``home and community-based long-term care services" means, with respect to a State Medicaid program, home and community-based services (including home health and personal care services) that are provided under the State's qualified HCB program or that could be provided under such a program but are otherwise provided under the Medicaid program.

(2) Eligible individual.--The term ``eligible individual" means, with respect to an MFP demonstration project of a State, an individual in the State--

[[Page 120 STAT. 103]]

(A) who, immediately before beginning participation in the MFP demonstration project--

(i) resides (and has resided, for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State) in an inpatient facility;

(ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and

(iii) with respect to whom a determination has been made that, but for the provision of home and community-based long-term care services, the individual would continue to require the level of care provided in an inpatient facility and, in any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, the individual must continue to require at least the level of care which had resulted in admission to the institution; and

(B) who resides in a qualified residence beginning on the initial date of participation in the demonstration project.

(3) Inpatient facility.--The term "inpatient facility" means a hospital, nursing facility, or intermediate care facility for the mentally retarded. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

(4) Medicaid.--The term "Medicaid" means, with respect to a State, the State program under title XIX of the Social Security Act (including any waiver or demonstration under such title or under section 1115 of such Act relating to such title).

(5) Qualified HCB program.--The term "qualified HCB program" means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority.

(6) Qualified residence.--The term "qualified residence" means, with respect to an eligible individual--

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential

setting, in which no more than 4 unrelated individuals reside.

(7) Qualified expenditures.--The term "qualified expenditures" means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility referred to in paragraph (2)(A)(i).

(8) Self-directed services.--The term "self-directed" means, with respect to home and community-based long-term

[[Page 120 STAT. 104]]

care services for an eligible individual, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative (as defined by the Secretary), including the amount, duration, scope, provider, and location of such services, under the State Medicaid program consistent with the following requirements:

(A) Assessment.--There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(B) Service plan.--Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that--

(i) specifies those services, if any, which the individual or the individual's authorized representative would be responsible for directing;

(ii) identifies the methods by which the individual or the individual's authorized representative or an agency designated by an individual or representative will select, manage, and dismiss providers of such services;

(iii) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(iv) is developed through a person-centered process that--

(I) is directed by the individual or the individual's authorized representative;

(II) builds upon the individual's capacity to engage in activities that

promote community life and that respects the individual's preferences, choices, and abilities; and

(III) involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(v) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(vi) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(C) Budget process.--With respect to individualized budgets described in subparagraph (B)(vi), the State application under subsection (c)--

(i) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(ii) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

[[Page 120 STAT. 105]]

(iii) provides a procedure to evaluate expenditures under such budgets.

(9) State.--The term "State" has the meaning given such term for purposes of title XIX of the Social Security Act.

(c) State Application.--A State seeking approval of an MFP demonstration project shall submit to the Secretary, at such time and in such format as the Secretary requires, an application meeting the following requirements and containing such additional information, provisions, and assurances, as the Secretary may require:

(1) Assurance of a public development process.--The application contains an assurance that the State has engaged, and will continue to engage, in a public process for the design, development, and evaluation of the MFP demonstration project that allows for input from eligible individuals, the families of such individuals, authorized representatives of such individuals, providers, and other interested parties.

(2) Operation in connection with qualified HCB program to

assure continuity of services.--The State will conduct the MFP demonstration project for eligible individuals in conjunction with the operation of a qualified HCB program that is in operation (or approved) in the State for such individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance.

(3) Demonstration project period.--The application shall specify the period of the MFP demonstration project, which shall include at least 2 consecutive fiscal years in the 5-fiscal-year period beginning with fiscal year 2007.

(4) Service area.--The application shall specify the service area or areas of the MFP demonstration project, which may be a statewide area or 1 or more geographic areas of the State.

(5) Targeted groups and numbers of individuals served.--The application shall specify--

(A) the target groups of eligible individuals to be assisted to transition from an inpatient facility to a qualified residence during each fiscal year of the MFP demonstration project;

(B) the projected numbers of eligible individuals in each targeted group of eligible individuals to be so assisted during each such year; and

(C) the estimated total annual qualified expenditures for each fiscal year of the MFP demonstration project.

(6) Individual choice, continuity of care.--The application shall contain assurances that--

(A) each eligible individual or the individual's authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP demonstration project;

(B) each eligible individual or the individual's authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive home and community-based long-term care services;

(C) the State will continue to make available, so long as the State operates its qualified HCB program consistent with applicable requirements, home and community-based

[[Page 120 STAT. 106]]

long-term care services to each individual who completes participation in the MFP demonstration project for as long as the individual remains eligible for medical assistance for such services under such qualified HCB program (including meeting a requirement relating to

requiring a level of care provided in an inpatient facility and continuing to require such services, and, if the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, meeting the requirement for at least the level of care which had resulted in the individual's admission to the institution).

(7) Rebalancing.--The application shall--

(A) provide such information as the Secretary may require concerning the dollar amounts of State Medicaid expenditures for the fiscal year, immediately preceding the first fiscal year of the State's MFP demonstration project, for long-term care services and the percentage of such expenditures that were for institutional long-term care services or were for home and community-based long-term care services;

(B)(i) specify the methods to be used by the State to increase, for each fiscal year during the MFP demonstration project, the dollar amount of such total expenditures for home and community-based long-term care services and the percentage of such total expenditures for long-term care services that are for home and community-based long-term care services; and

(ii) describe the extent to which the MFP demonstration project will contribute to accomplishment of objectives described in subsection (a).

(8) Money follows the person.--The application shall describe the methods to be used by the State to eliminate any legal, budgetary, or other barriers to flexibility in the availability of Medicaid funds to pay for long-term care services for eligible individuals participating in the project in the appropriate settings of their choice, including costs to transition from an institutional setting to a qualified residence.

(9) Maintenance of effort and cost-effectiveness.--The application shall contain or be accompanied by such information and assurances as may be required to satisfy the Secretary that--

(A) total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for--

(i) fiscal year 2005; or

(ii) any succeeding fiscal year before the first year of the MFP demonstration project; and

(B) in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section

1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness

[[Page 120 STAT. 107]]

requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

(10) Waiver requests.--The application shall contain or be accompanied by requests for any modification or adjustment of waivers of Medicaid requirements described in subsection (d)(3), including adjustments to the maximum numbers of individuals included and package of benefits, including one-time transitional services, provided.

(11) Quality assurance and quality improvement.--The application shall include--

(A) a plan satisfactory to the Secretary for quality assurance and quality improvement for home and community-based long-term care services under the State Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration project; and

(B) an assurance that the State will cooperate in carrying out activities under subsection (f) to develop and implement continuous quality assurance and quality improvement systems for home and community-based long-term care services.

(12) Optional program for self-directed services.--If the State elects to provide for any home and community-based long-term care services as self-directed services (as defined in subsection (b)(8)) under the MFP demonstration project, the application shall provide the following:

(A) Meeting requirements.--A description of how the project will meet the applicable requirements of such subsection for the provision of self-directed services.

(B) Voluntary election.--A description of how eligible individuals will be provided with the opportunity to make an informed election to receive self-directed services under the project and after the end of the project.

(C) State support in service plan development.--Satisfactory assurances that the State will provide support to eligible individuals who self-direct in developing and implementing their service plans.

(D) Oversight of receipt of services.--Satisfactory assurances that the State will provide oversight of eligible individual's receipt of such self-directed

services, including steps to assure the quality of services provided and that the provision of such services are consistent with the service plan under such subsection.

Nothing in this section shall be construed as requiring a State to make an election under the project to provide for home and community-based long-term care services as self-directed services, or as requiring an individual to elect to receive self-directed services under the project.

(13) Reports and evaluation.--The application shall provide that--

(A) the State will furnish to the Secretary such reports concerning the MFP demonstration project, on such timetable, in such uniform format, and containing such information as the Secretary may require, as will allow for reliable comparisons of MFP demonstration projects across States; and

[[Page 120 STAT. 108]]

(B) the State will participate in and cooperate with the evaluation of the MFP demonstration project.

(d) Secretary's Award of Competitive Grants.--

(1) In general.--The Secretary shall award grants under this section on a competitive basis to States selected from among those with applications meeting the requirements of subsection (c), in accordance with the provisions of this subsection.

(2) Selection and modification of state applications.--In selecting State applications for the awarding of such a grant, the Secretary--

(A) shall take into consideration the manner in which, and extent to which, the State proposes to achieve the objectives specified in subsection (a);

(B) shall seek to achieve an appropriate national balance in the numbers of eligible individuals, within different target groups of eligible individuals, who are assisted to transition to qualified residences under MFP demonstration projects, and in the geographic distribution of States operating MFP demonstration projects;

(C) shall give preference to State applications proposing--

(i) to provide transition assistance to eligible individuals within multiple target groups; and

(ii) to provide eligible individuals with the opportunity to receive home and community-based long-term care services as self-directed services,

as defined in subsection (b)(8); and

(D) shall take such objectives into consideration in setting the annual amounts of State grant awards under this section.

(3) Waiver authority.--The Secretary is authorized to waive the following provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of this section:

(A) Statewideness.--Section 1902(a)(1), in order to permit implementation of a State initiative in a selected area or areas of the State.

(B) Comparability.--Section 1902(a)(10)(B), in order to permit a State initiative to assist a selected category or categories of individuals described in subsection (b)(2)(A).

(C) Income and resources eligibility.--Section 1902(a)(10)(C)(i)(III), in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

(D) Provider agreements.--Section 1902(a)(27), in order to permit a State to implement self-directed services in a cost-effective manner.

(4) Conditional approval of outyear grant.--In awarding grants under this section, the Secretary shall condition the grant for the second and any subsequent fiscal years of the grant period on the following:

(A) Numerical benchmarks.--The State must demonstrate to the satisfaction of the Secretary that it is meeting numerical benchmarks specified in the grant agreement for--

[[Page 120 STAT. 109]]

(i) increasing State Medicaid support for home and community-based long-term care services under subsection (c)(5); and

(ii) numbers of eligible individuals assisted to transition to qualified residences.

(B) Quality of care.--The State must demonstrate to the satisfaction of the Secretary that it is meeting the requirements under subsection (c)(11) to assure the health and welfare of MFP demonstration project participants.

(e) Payments to States; Carryover of Unused Grant Amounts.--

(1) Payments.--For each calendar quarter in a fiscal year during the period a State is awarded a grant under subsection (d), the Secretary shall pay to the State from its grant award for such fiscal year an amount equal to the lesser of--

(A) the MFP-enhanced FMAP (as defined in paragraph (5)) of the amount of qualified expenditures made during such quarter; or

(B) the total amount remaining in such grant award for such fiscal year (taking into account the application of paragraph (2)).

(2) Carryover of unused amounts.--Any portion of a State grant award for a fiscal year under this section remaining at the end of such fiscal year shall remain available to the State for the next 4 fiscal years, subject to paragraph (3).

(3) Rewarding of certain unused amounts.--In the case of a State that the Secretary determines pursuant to subsection (d)(4) has failed to meet the conditions for continuation of a MFP demonstration project under this section in a succeeding year or years, the Secretary shall rescind the grant awards for such succeeding year or years, together with any unspent portion of an award for prior years, and shall add such amounts to the appropriation for the immediately succeeding fiscal year for grants under this section.

(4) Preventing duplication of payment.--The payment under a MFP demonstration project with respect to qualified expenditures shall be in lieu of any payment with respect to such expenditures that could otherwise be paid under Medicaid, including under section 1903(a) of the Social Security Act. Nothing in the previous sentence shall be construed as preventing the payment under Medicaid for such expenditures in a grant year after amounts available to pay for such expenditures under the MFP demonstration project have been exhausted.

(5) MFP-enhanced fmap.--For purposes of paragraph (1)(A), the "MFP-enhanced FMAP", for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 50 percent of the number of percentage points by which (A) such Federal medical assistance percentage for the State, is less than (B) 100 percent; but in no case shall the MFP-enhanced FMAP for a State exceed 90 percent.

(f) Quality Assurance and Improvement; Technical Assistance; Oversight.--

[[Page 120 STAT. 110]]

(1) <<NOTE: Contracts.>> In general.--The Secretary, either directly or by grant or contract, shall provide for technical assistance to, and oversight of, States for purposes of upgrading quality assurance and quality improvement systems under Medicaid home and community-based waivers, including--

(A) dissemination of information on promising

practices;

(B) guidance on system design elements addressing the unique needs of participating beneficiaries;

(C) ongoing consultation on quality, including assistance in developing necessary tools, resources, and monitoring systems; and

(D) guidance on remedying programmatic and systemic problems.

(2) Funding.--From the amounts appropriated under subsection (h)(1) for the portion of fiscal year 2007 that begins on January 1, 2007, and ends on September 30, 2007, and for fiscal year 2008, not more than \$2,400,000 shall be available to the Secretary to carry out this subsection during the period that begins on January 1, 2007, and ends on September 30, 2011.

(g) Research and Evaluation.--

(1) <<NOTE: Contracts.>> In general.--The Secretary, directly or through grant or contract, shall provide for research on, and a national evaluation of, the program under this section, including assistance to the Secretary in preparing the final report required under paragraph (2). The evaluation shall include an analysis of projected and actual savings related to the transition of individuals to qualified residences in each State conducting an MFP demonstration project.

(2) Final report.--The Secretary shall make a final report to the President and Congress, not later than September 30, 2011, reflecting the evaluation described in paragraph (1) and providing findings and conclusions on the conduct and effectiveness of MFP demonstration projects.

(3) Funding.--From the amounts appropriated under subsection (h)(1) for each of fiscal years 2008 through 2011, not more than \$1,100,000 per year shall be available to the Secretary to carry out this subsection.

(h) Appropriations.--

(1) In general.--There are appropriated, from any funds in the Treasury not otherwise appropriated, for grants to carry out this section--

(A) \$250,000,000 for the portion of fiscal year 2007 beginning on January 1, 2007, and ending on September 30, 2007;

(B) \$300,000,000 for fiscal year 2008;

(C) \$350,000,000 for fiscal year 2009;

(D) \$400,000,000 for fiscal year 2010; and

(E) \$450,000,000 for fiscal year 2011.

(2) Availability.--Amounts made available under paragraph (1) for a fiscal year shall remain available for the awarding of grants to States by not later than September 30, 2011.

[[Page 120 STAT. 111]]

600.7 Structure and Administration

The Georgia Department of Community Health

The Georgia Department of Community Health (DCH) was created in 1999, with the responsibility for insuring over two million people in the State of Georgia, to maximize the State's health care purchasing power and to coordinate health planning for state agencies. DCH is designated as the "single State agency" for the administration of the Medicaid program under Title XIX of the Social Security Act. The Money Follows the Person Demonstration takes rebalancing to the next level in Georgia.

In May 2007, the Centers of Medicare and Medicaid Services (CMS) awarded Georgia the Money Follows the Person (MFP) Rebalancing Demonstration grant established by the Deficit Reduction Act of 2005. The MFP grant affords Georgia the opportunity to further rebalance the system of care, allowing the State to eliminate barriers or mechanisms that prevent or restrict flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the setting of their choice.

The Department of Community Health (DCH) is the administrator of the MFP Project and is responsible for all aspects of its successful implementation. As such, it acts as the overall coordinator for policy and operational issues related to the MFP Demonstration and works with various stakeholders, State departments, local governments, community-based organizations, inpatient health care facilities (hospitals, nursing or sub-acute care facilities, or intermediate care facilities for persons with Mental Retardation), advocates, and consumer groups to implement the project at the local level.

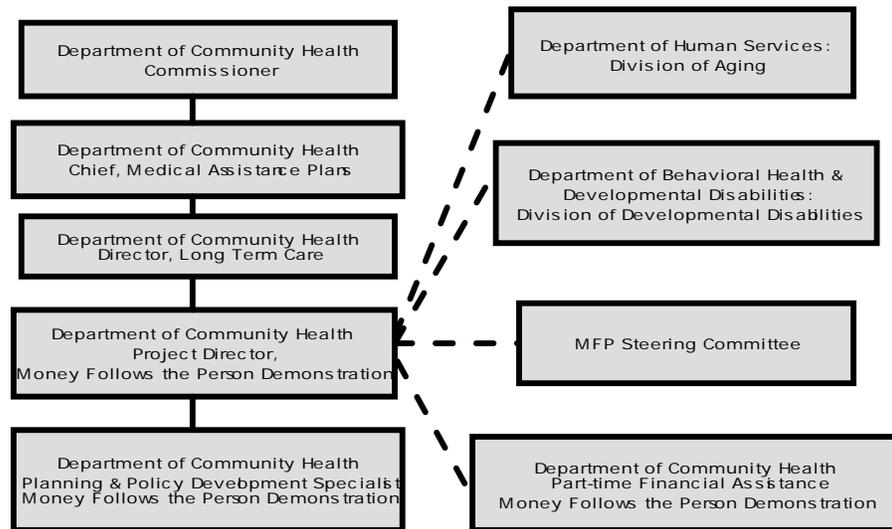
Rev. 07/10

Overall authority, administration, oversight and supervision of Georgia's MFP demonstration reside in the Medicaid Division in the Department of Community Health (DCH). DCH is the Lead Medicaid State Agency.

Rev. 07/10

The MFP Project Director and Project Specialists are employed by DCH. DCH is responsible for administering and implementing Georgia's demonstration in accordance with the approval of this operational protocol by CMS. The Project Director provides direct management of the MFP project under the supervision of the Medicaid Division Deputy Director of Long Term Care. A Planning & Policy Development Specialist undertakes planning and policy research and development for the MFP project under the supervision of the MFP Project Director. A MFP Housing Specialist undertakes related tasks under the supervision of the MFP Project Director. An Information Technology Specialist undertakes related tasks under the supervision of the MFP Project Director. A Project Coordinator, employed by the Department of Behavioral Health and Developmental Disabilities, manages activities in DBHDD and serves as a liaison to the MFP Project Director.

Georgia's MFP Demonstration Organizational Chart



MFP Staffing Plan

As the chart above indicates, the authority for the administration and supervision of the MFP Program will reside in the Medicaid Division in the Department of Community Health (DCH), the recipient of the MFP grant award. DCH is responsible for ensuring the grant is implemented according to the operational protocol design approved by CMS to include tracking expenditures and Maintenance Of Effort targets, financial reporting, semi-annual progress reports, and coordination with the national contractors for technical assistance and evaluation.

Rev. 07/10

The MFP Project Director and Project Specialists, all employees of DCH, carry out the responsibilities residing in DCH and for interagency coordination in the implementation and evaluation of the MFP Demonstration, under the supervision of the Medicaid Division Deputy Director for Long Term Care.

The MFP Project Director responsibilities include:

- oversees execution of the RFP process to hire transition coordinator contractor
- identifies appropriate information, resources and technical assistance necessary for the awarded contractor to complete assigned tasks
- provides the operational policies and procedures
- conducts programmatic reviews and audits, monitoring, quality assurance and quality improvement
- reviews and approves the DCH private vendor's contract deliverables related to the demonstration project
- monitors grant expenditures against approved limits

- provides on-going guidance and project coordination within DCH and the Department of Human Services,
- reviews participant service plans to ensure program requirements are met
- establishes prior authorization limits
- sets reimbursement rates
- performs utilization management functions and consumers' surveys data
- conducts statewide stakeholders forums

Rev. 07/10

The day-to-day management of the Elderly and Disabled waiver programs (CCSP and SOURCE) requires the joint effort of DCH and DHS. The day-to-day management of the NOW and COMP waivers requires the joint efforts of DCH and DBHDD.

The Independent Care Waiver Program (ICWP) is managed by the Medicaid Division at DCH. MFP TCs will partner with the Georgia Medical Care Foundation (the assessment entity for the ICWP waiver), Aging and Disability Resource Connections (ADRCs), Georgia Centers for Independent Living (CILs), the Brain and Spinal Injury Trust Fund Commission, Side by Side Brain Injury Clubhouse, Community Service Boards and regional and local service provider networks to serve persons with physical disabilities and/or Acquired brain injury (ABI) through ICWP, CCSP and SOURCE programs.

Division of Family and Children Services

DCH, the agency responsible for funding MFP, contracts with Division of Family and Children Services (DFCS) to provide Medicaid eligibility determinations for MFP participants. DFCS also determines eligibility for Food Stamps, Child Protective Services, Temporary Assistance to Needy Families, and various community based programs. DFCS Medicaid eligibility specialists are responsible for:

- changing MFP participants from institutional (nursing facility) to home and community waiver service eligibility
- Determining Medicaid eligibility locally, through the DFCS office located in the county of a MFP participant's choice of residence
- Determining the MFP participant's waiver cost share, if MAO/PMAO
- Communicating eligibility and cost share information with MFP TCs and waiver case managers.

The Georgia Department of Human Services

The Department of Human Services (DHS) is the state agency responsible for the delivery of health and social services. DHS was created by the Georgia General Assembly in the Governmental Reorganization Act of 1972. The agency is responsible for general administration of Aging Services (DAS) and Family and Children Services (DFCS).

DHS, Division of Aging Services, AAA/Gateway network and ADRCs

The Division of Aging Services (DAS) within the Department of Human Services (DHS), administers CCSP in coordination with the Medicaid Division of the Department of Community Health (DCH). DAS contracts with Area Agencies on Aging (AAA) to administer CCSP locally. The Division of Aging Services designates the AAA to serve as lead agency for CCSP in each planning and service areas. The AAA is the gateway or community focal point through which aging programs are planned and coordinated (see *Appendix F: Area Agency on Aging*).

MFP Transition Coordinators (TCs) refer potential MFP participants to the AAA/Gateway for waiver screening. MFP TCs receive friendly referrals from the AAA/Gateway network and from the Aging and Disability Resources Connections (ADRC). Integration of MFP participants into appropriate waivers depends on coordination and communication of:

- DCH/Medicaid Division, Long-Term Care, MFP staff
- AAA/Gateway and Aging and Disability Resource Connections (ADRCs)
- State DFCS, DHS, and county DFCS eligibility caseworkers and Adult Protective Services caseworkers
- Healthcare Facility Regulation Division, DCH
- Elderly and Disabled Waiver (CCSP and SOURCE) case managers
- Service providers.

The Georgia Department of Behavioral Health and Developmental Disabilities

DBHDD serves people of all ages and those most in need of mental health, developmental disability, or addictive diseases services. Georgia's DBHDD regional offices, the State's DD Council, the Association of Retarded Citizens (ARC), People First Georgia, Unlock the Waiting Lists are all contact points for people needing mental health and/or developmental disability services. The regional offices are responsible for planning, coordination, contracting for services and evaluating all publicly supported hospital and community programs.

Services are provided statewide with DBHDD Community Service Boards and private providers. In addition to providing treatment and support services, community programs refer and screen potential MFP participants and arrange for MFP transition services and waiver services and supports through the NOW and COMP waiver programs.

MFP Steering Committee

The MFP Steering Committee meets quarterly and is composed of representatives from all stakeholder groups including:

- Georgia State agencies - the DCH Medicaid Division Deputy Director for Long Term Care, MFP program staff and HCBS waiver program managers, representatives from the Department of Human Services Division of Aging Services (DAS) and the Department of Behavioral Health and Developmental Disabilities;
- Partnering agencies, the Area Agencies on Aging/Gateway Network and the Aging and Disability Resource Connections (ADRCs), Georgia Council on Aging;
- Legal and professional disability advocates including the Georgia Council of Developmental Disability (GCDD), Georgia Legal Aid Society, Georgia Advocacy Office, People First of Georgia, the Association of Retarded Citizens of Georgia, Georgia Centers for Independent Living (CILs), the director of the Georgia Independent Living Network (GILN) and LTC Ombudsmen from around the State;
- Vendors and service providers
- Housing officials from the State's Housing Finance Authority, the Department of Community Affairs and housing professionals from Metro Area Public Housing Authorities.
- State compliance and evaluation professionals.

Throughout the years of the demonstration, stakeholders will be asked to provide input using forums, work groups, surveys, interviews, observations and trainings. During implementation, successfully resettled waiver participants, family members and care givers will be asked to provide encouragement and support, such as sharing experiences, to MFP members resettling in the community.

As needed, to insure full participation of stakeholders, meetings will be held throughout the state in accessible venues and transportation costs incurred by consumers will be reimbursed, if requested. These participatory methods strengthen MFP, empower full and direct stakeholder participation and assist the State to identify areas of development and improvement. Openness, transparency and sustainability are the hallmarks of Georgia MFP. Methods that actively engaged stakeholders are necessary to produce the highest quality transition programs and services.

CHAPTER 601

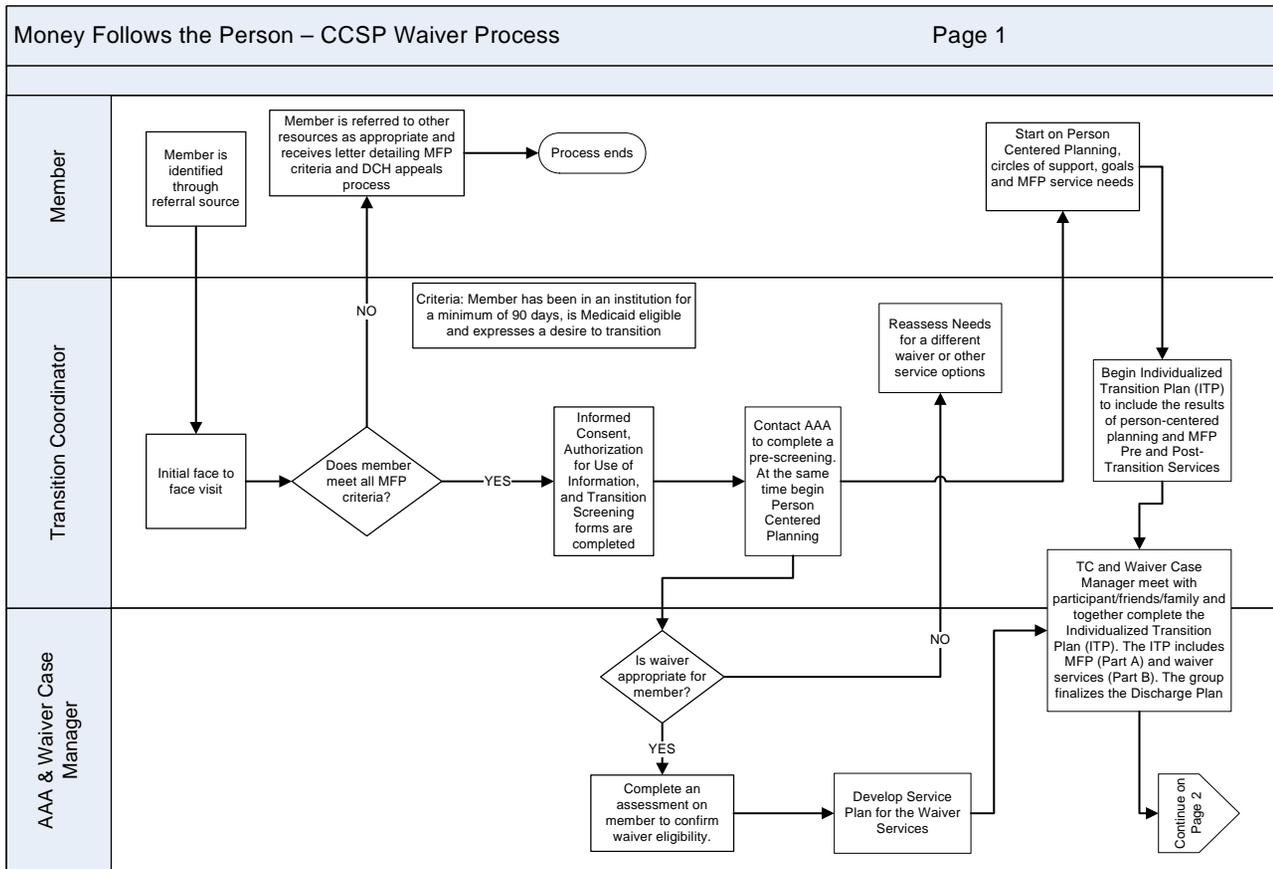
INTEGRATED MFP AND WAIVER PROCESSES

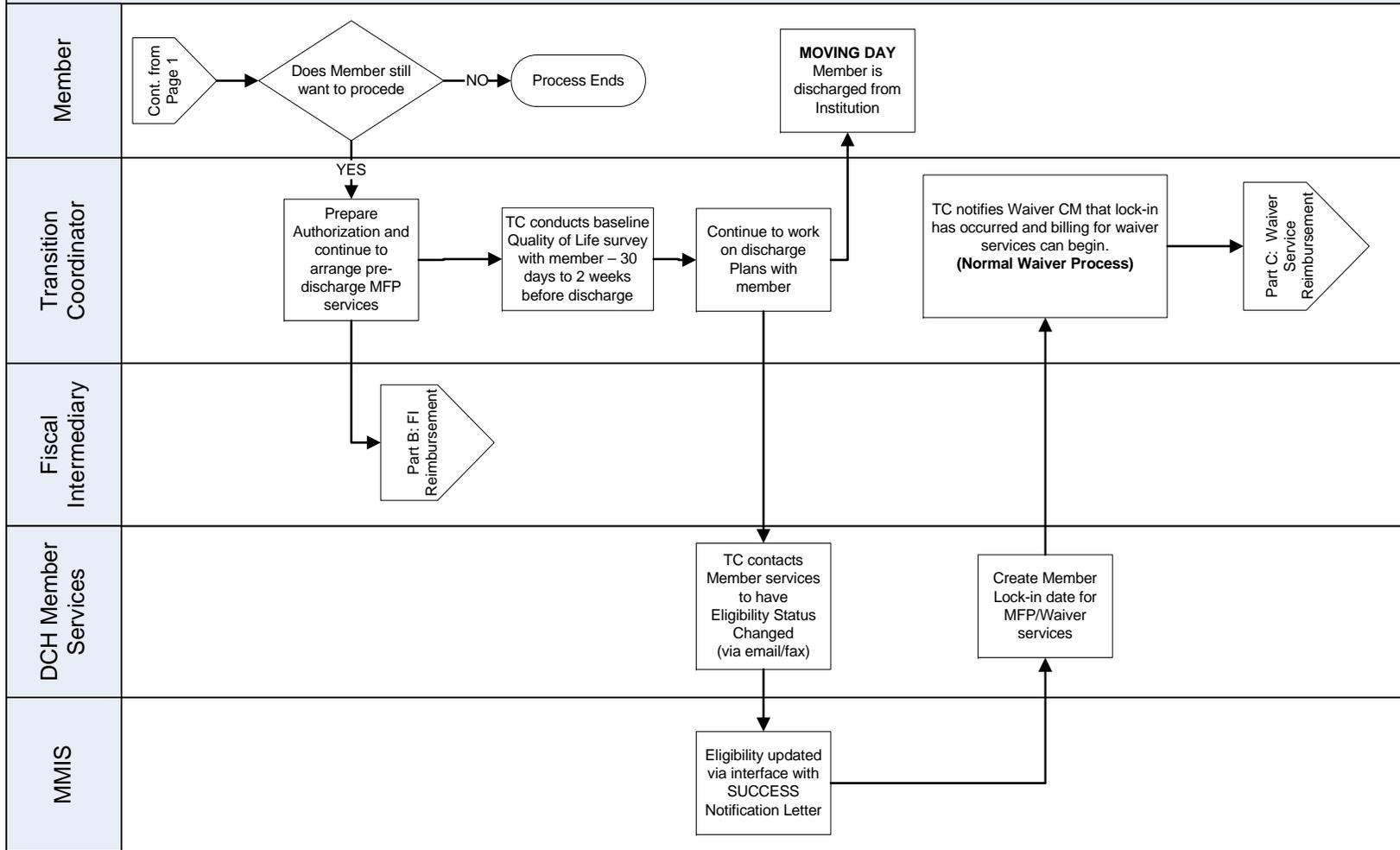
601.0 Introduction to Process Flowcharts & Text Descriptions

The following section provides an overview of MFP processes as summarized by flowcharts and text descriptions.

601.1 Elderly and Disabled Waiver-CCSP Process

Rev. 07/10





MFP CCSP Waiver Process

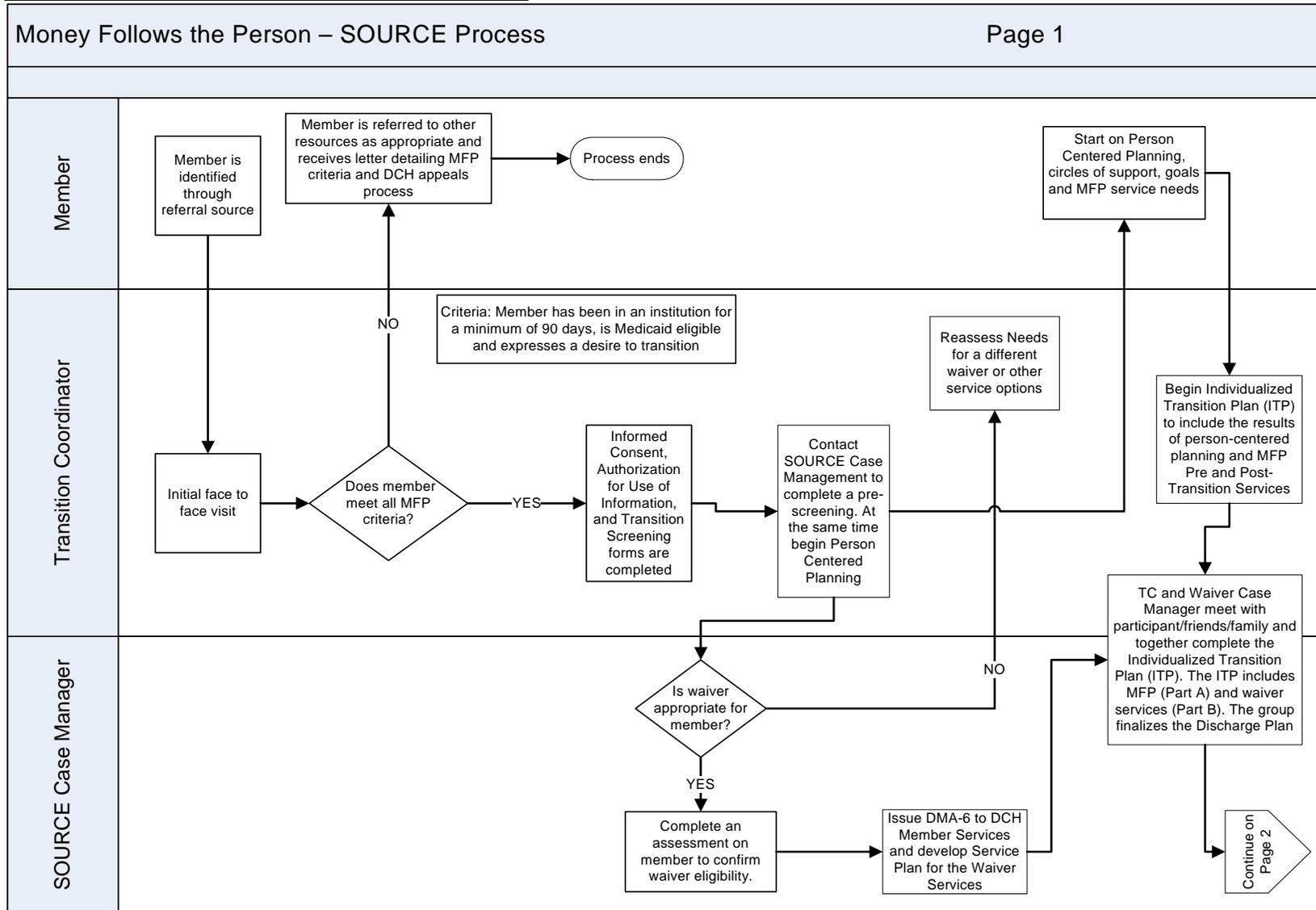
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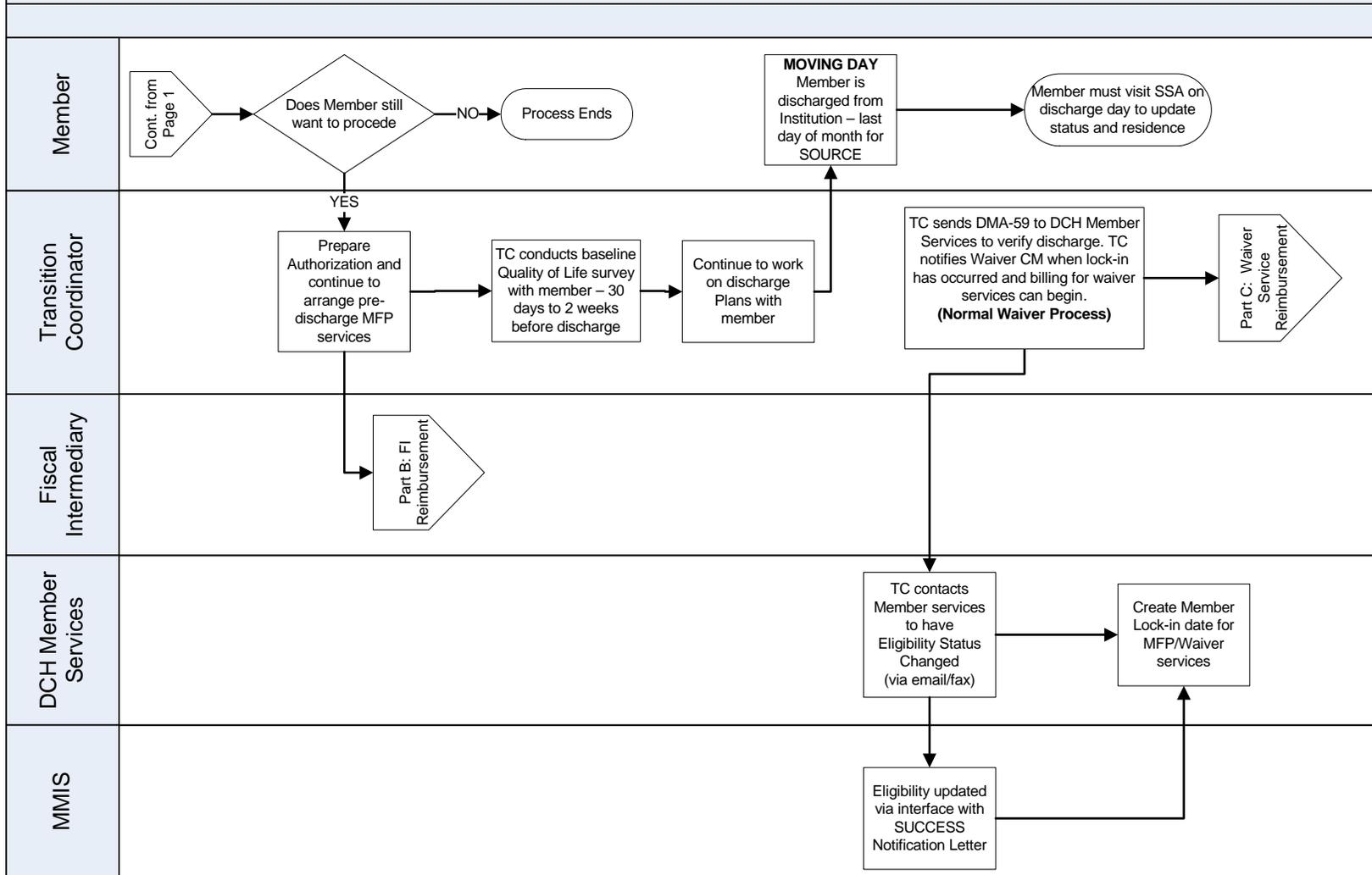
1. Participant is identified through referral sources as potentially eligible for MFP
2. Transition Coordinator (TC) meets with participant and representatives at NF to determine appropriateness for MFP
 - Has been in facility for at least 90 days--short-term rehabilitation stays of 90 days or less do not count
 - Medicaid has paid for facility stay for at least one day (24 hour period) during the most current month
 - Meets nursing home level of care
 - Desires to transition
3. If participant does not meet criteria, TC informs of other options and makes appropriate referrals
 - TC issues letter explaining reason for ineligibility & DCH rights to appeal
4. If participant meets criteria, completes and signs *Authorization For Release of Information* and *Informed Consent forms*
5. TC completes *MFP Transition Screening Form* and sends to DCH within 3 business days of completion
6. To refer to CCSP, TC contacts local AAA Gateway/ADRC to complete screening for waiver eligibility. Assists participant with waiver applications as necessary.
7. If waiver is not appropriate, reassess needs and refer to other waiver or service options
8. If waiver is appropriate, proceed with person-directed planning process
9. Begin *Individualized Transition Plan* by scheduling ITP meeting with participant, family, friends, LTC Ombudsman, NH staff, waiver case manager, and others as appropriate
10. Determine needs for MFP pre- and post-transition services and document in the ITP.
11. Assign responsibilities to ITP team participants and plan for discharge
12. TC completes *Authorization for Transition Services* identified in the ITP meeting and submits to Acumen and DCH
13. Household furnishings, goods and supplies for transition arranged no earlier than 10 days prior to discharge date
14. TC conducts the *Quality of Life* survey with participant 30 days to 2 weeks prior to discharge
15. TC contacts Member Services in DCH to have eligibility status changed from institutional to community Medicaid (refer to Section 604.5 for more information on completing this step of the process)
16. Discharge date is day one of 365-day lock-in period of MFP services for participant
17. TC visits participant within the first week and monthly for the 365-day period
18. Waiver services continue throughout the 365-day period and are uninterrupted at the end of MFP
19. One month prior to the end of the MFP 365-day period, TC issues notification that MFP will end and waiver services will continue as normal

Rev. 07/10

601.2 Elderly and Disabled Waiver-SOURCE Process

Rev. 07/10



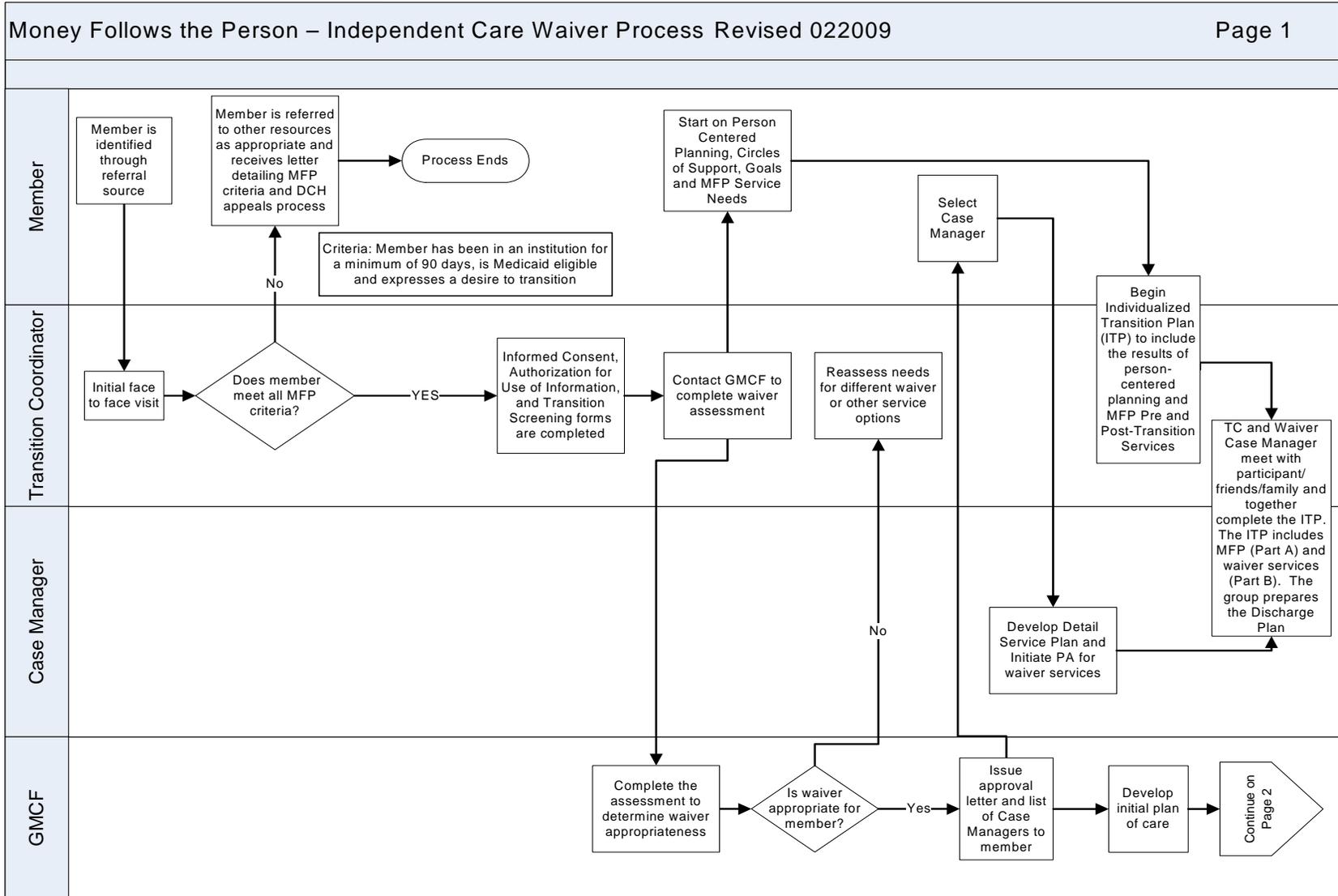


MFP SOURCE Waiver Process

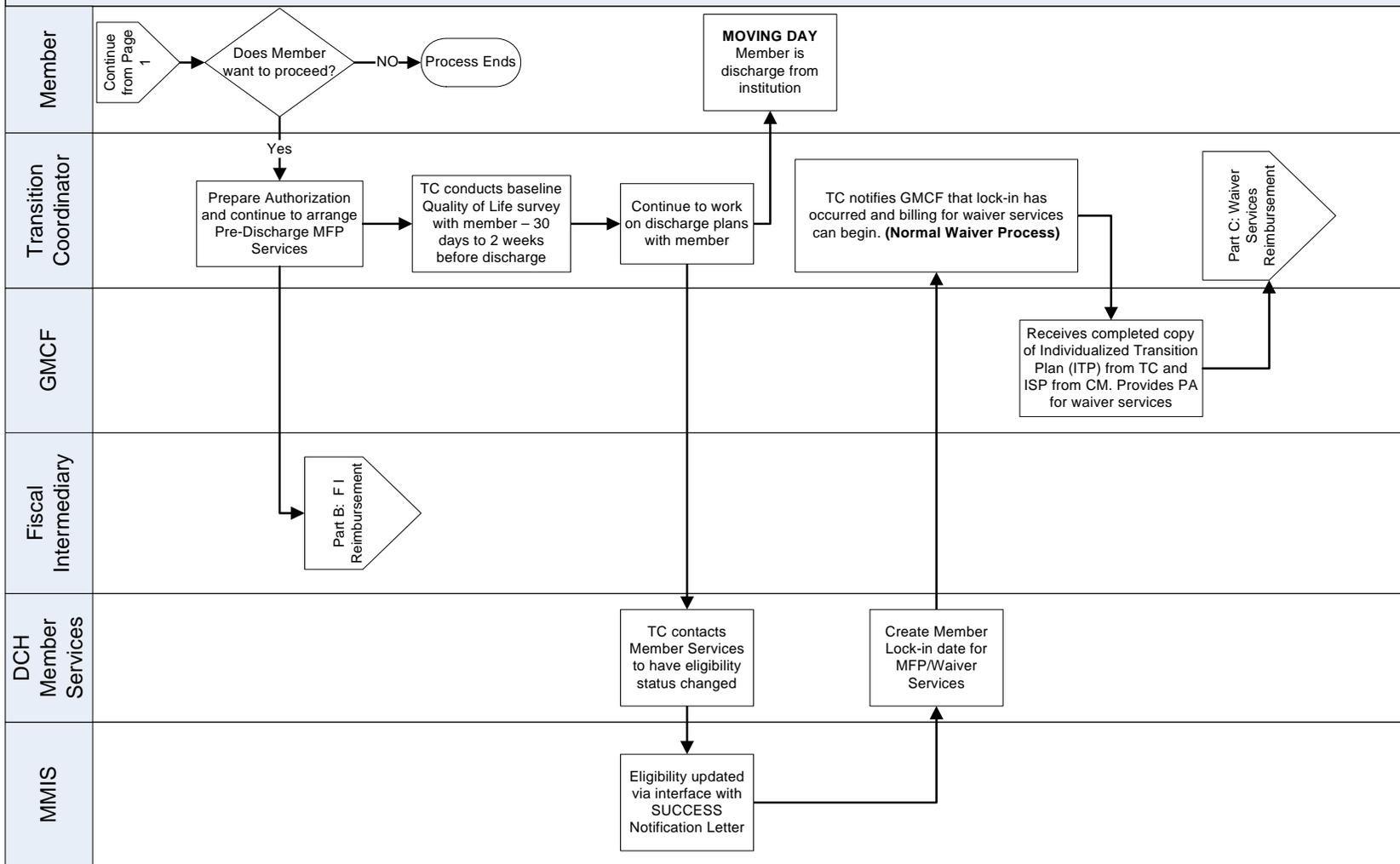
1. Participant is identified through referral sources as potentially eligible for MFP
2. Transition Coordinator (TC) meets with participant and representatives at NF to determine appropriateness for MFP
 - Has been in facility for at least 90 days--short-term rehabilitation stays of 90 days or less do not count
 - Medicaid has paid for facility stay for at least one day (24 hour period) during the most current month
 - Meets nursing home level of care
 - Desires to transition
3. If participant does not meet criteria, TC informs of other options and makes appropriate referrals
 - TC issues letter explaining reason for ineligibility & DCH rights to appeal
4. If participant meets criteria, completes and signs *Authorization For Release of Information* and *Informed Consent forms*
5. TC completes *MFP Transition Screening Form* and sends to DCH within 3 business days of completion
6. To refer to SOURCE, TC provides the participant with a listing of SOURCE case management agencies that serve the participant's county (see *Appendix I* of this manual). Once the participant has selected a case management agency, the TC contacts that agency to complete screening for waiver eligibility. Assists participant with waiver applications as necessary.
7. If waiver is not appropriate, reassess needs and refer to other waiver or service options
8. If waiver is appropriate, proceed with person-directed planning process
9. Begin *Individualized Transition Plan* by scheduling ITP meeting with participant, family, friends, Ombudsman, NH staff, waiver case manager, and others as appropriate
10. Determine needs for MFP pre- and post-transition services and document in the ITP.
11. Assign responsibilities to ITP team participants and plan for discharge
12. TC completes *Authorization for Transition Services* identified in the ITP meeting and submits to Acumen and DCH
13. Household furnishings, goods and supplies for transition arranged no earlier than 10 days prior to discharge date
14. TC conducts the *Quality of Life* survey with participant 30 days to 2 weeks prior to discharge
15. Once SOURCE Case Management has a DMA-6, this should be sent to DCH Member Services through the usual process.
16. Discharge for SOURCE participants must happen on the last day of the month, and it must happen early in the day. Due to the required visit to the SSA, discharges should not take place in months where the last day falls on a weekend or holiday.
17. TC sends the DMA-59 to the Medicaid Program Consultant at DCH as early as possible on the day of discharge. DCH forwards to the Medicaid Eligibility Specialist with DFCS Long Term Care Unit to initiate close-out of NH status.
18. TC must arrange for the participant to be taken to the Social Security Administration on the date of discharge.
19. For those who remained on SSI while in the NH, this step will be to confirm discharge and new living arrangement so that they can begin receiving their full check.
20. For those who lost SSI eligibility while in the NH, this step will be to re-establish eligibility and receive a cert letter (letter may be received that day or may be issued by SSA at a later date).

21. Once a certification letter has been received from SSA, the TC sends this letter to the DCH Medicaid Program Consultant ASAP. DCH updates the Medicaid system with member SSI eligibility and communicates with DFCS Medicaid Eligibility Specialist to complete termination of NH Medicaid eligibility.
22. Once DCH and DFCS Long Term Care Unit have closed out NH status, DCH Medicaid Program Consultant communicates with the DCH Member Services Office Manager that the cert letter has been received and the system updated. Member Services goes into the system and dates the SOURCE and MFP lock-in spans retroactive to the date of discharge.
23. Discharge date is day one of 365-day lock-in period of MFP services for participant
24. TC visits participant within the first week and monthly for the 365-day period
25. Waiver services continue throughout the 365-day period and are uninterrupted at the end of MFP
26. One month prior to the end of the MFP 365-day period, TC issues notification that MFP will end and waiver services will continue as normal

601.3 Independent Care Waiver Process



Rev. 07/10

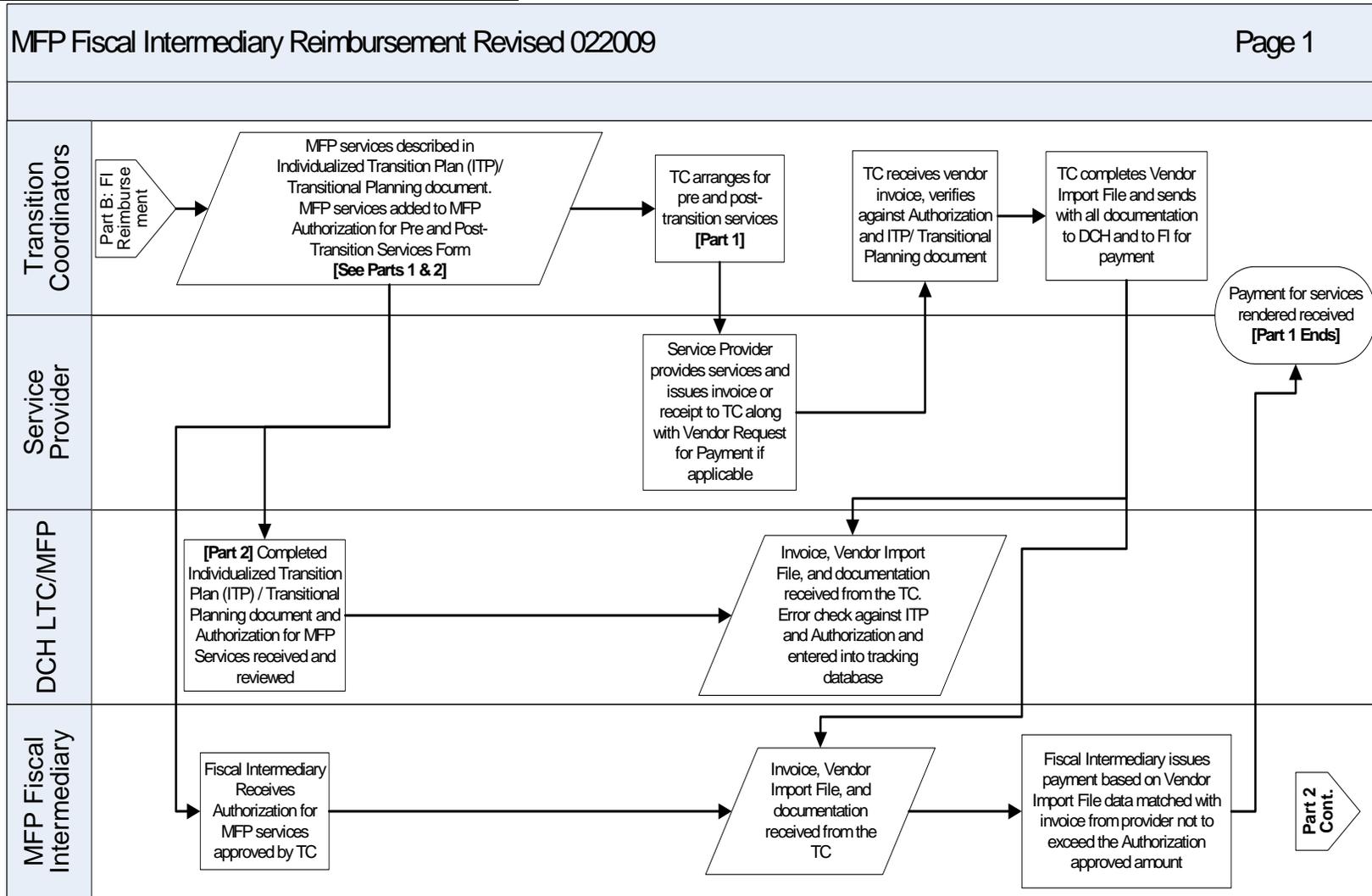


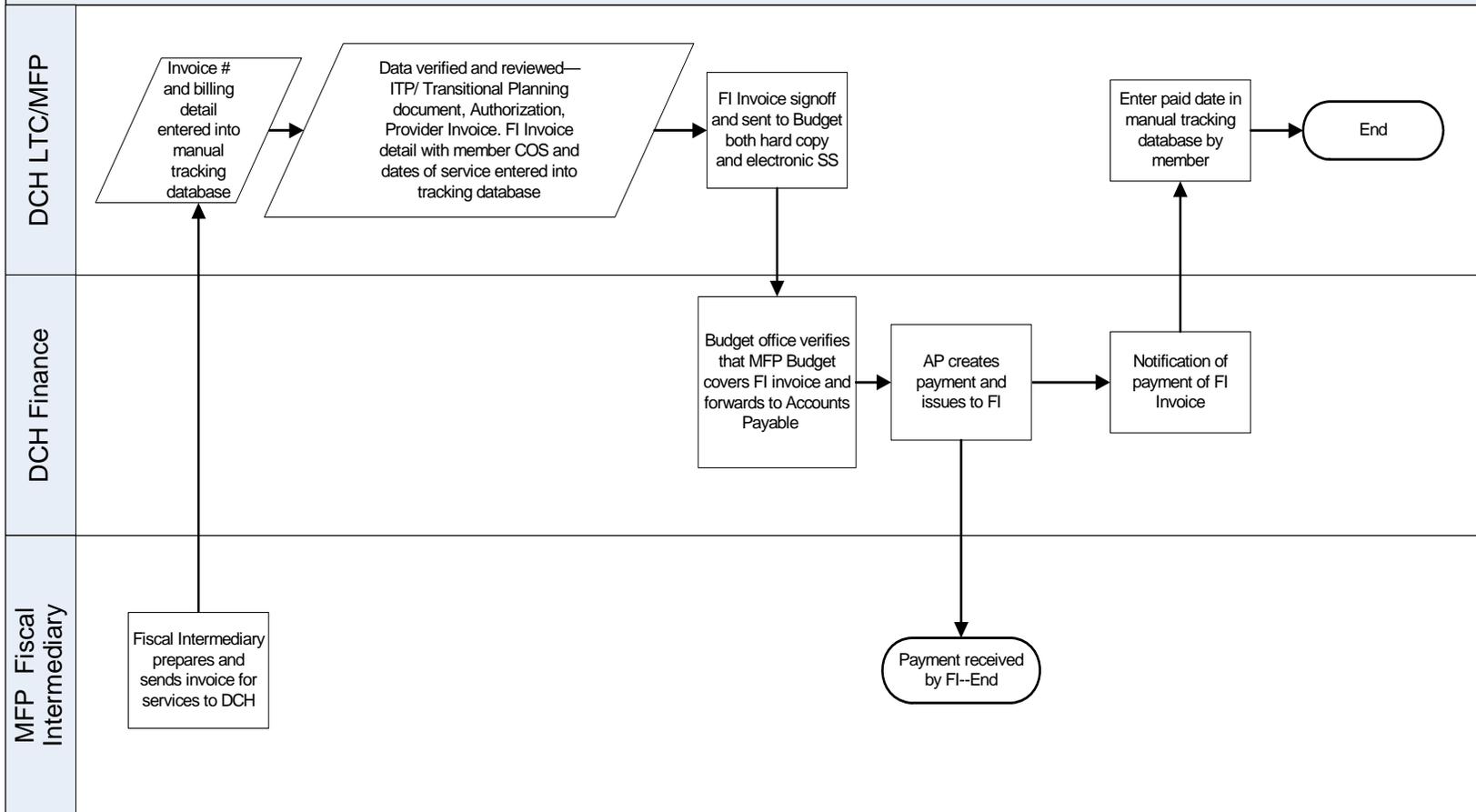
MFP ICWP Waiver Process

Rev. 07/10

1. Participant is identified through referral sources as potentially eligible for MFP
 2. TC meets with participant and representatives at NF to determine appropriateness for MFP
 - Has been in facility for at least 90 days--short-term rehabilitation stays of 90 days or less do not count
 - Medicaid has paid for at least one day during the most recent month's facility stay
 - Meets nursing home level of care
 - Desires to transition
 3. If participant does not meet criteria, TC informs of other options and makes appropriate referrals
 - TC Contractor issues letter explaining reason for ineligibility & DCH rights to appeal
 4. If participant meets criteria, completes and signs *Authorization For Release of Information* and *Informed Consent*
 5. TC completes *MFP Transition Screening Form* and sends to DCH within 3 business days of completion
 6. To refer to ICWP, TC contacts GMCF to complete screening for ICWP waiver eligibility
 - If participant is already on ICWP waiting list, TC notifies GMCF and GMCF issues approval letter to participant
 - If participant is not on ICWP waiting list, TC will help participant to complete application and submit to GMCF with referral
 7. If waiver is not appropriate, reassess needs and refer to other waiver or service options
 8. If waiver is appropriate, GMCF will issue approval letter and list of ICWP case managers for participant to select
 9. TC can assist participant to select case manager and proceed with person-directed planning process
 10. Begin *Individualized Transition Plan* by scheduling ITP meeting with participant, family, friends, Ombudsman, NH staff, waiver case manager, and others as appropriate
 11. Determine needs for MFP pre- and post-transition services and document in ITP
 12. Assign responsibilities to ITP team participants and plan for discharge
 13. TC completes *Authorization for Transition Services* identified in the ITP meeting and submits to Acumen and DCH
- Rev. 07/10
14. Household furnishings, goods and supplies for transition arranged no earlier than 10 days prior to discharge date
 15. TC conducts the *Quality of Life* survey with participant 30 days to 2 weeks prior to discharge
 16. TC contacts Member Services in DCH/DFCS to have eligibility status changed from institutional to community Medicaid (refer to Section 604.5 for more information on completing this step of the process)
 17. Discharge date is day one of 365-day lock-in period of MFP services for participant
 18. TC visits participant within the first week and monthly for the 365-day period
 19. Waiver services continue throughout the 365-day period and are uninterrupted at the end of MFP
 20. One month prior to the end of the MFP 365-day period, TC issues notification that MFP will end and waiver services will continue as normal

601.4 Fiscal Intermediary Reimbursement Process





MFP FI Reimbursement Process Text Descriptions

For Transition Coordinator Contractor Payment – Initial Authorization

1. Screening
2. ITP Meeting – develops list of MFP pre- and post-transition services needed, rationale, and budget
3. Research (pricing, availability) done by person & team to locate resources
4. Transition Coordinator completes initial authorization form (check “initial” on the form) and sends to Fiscal Intermediary and DCH via FTP for identified needs
5. Household furnishings, goods and supplies purchased and/or arranged – no earlier than 10 days prior to discharge unless DCH has given prior approval
 - TC separates household furnishings, goods and supplies purchases for different individuals or different services onto separate receipts (i.e., household goods for person A separate receipt from furnishings for person A)
6. TC Contractor pays for items that require up-front payment
7. Discharge
8. TC completes *Vendor Import File* and sends to Fiscal Intermediary and DCH along with receipts
 - TC notes name of individual on copy of receipt
9. Fiscal Intermediary confirms that line items on *Vendor Import File* correspond to receipts and do not exceed authorized amounts or caps
10. Fiscal Intermediary issues payment to TC CONTRACTOR
11. Fiscal Intermediary issues invoice to MFP office at DCH (with subtotals for regular, enhanced, and admin fees)
12. MFP office adds all authorized/spent amounts for services to MFP manual tracking database
13. MFP office reviews Fiscal Intermediary invoice against ITP, *Vendor Import File*, supporting receipts, and authorizations to ensure caps and authorizations were not exceeded
14. MFP office authorizes DCH Finance to issue payment to Fiscal Intermediary via signoff
15. Fiscal Intermediary is paid
16. If TC purchased items that are not allowable or bills before discharge, process for recoupment is initiated internally at DCH

Outside Vendor Payment (TC Contractor, LTCO, etc.) – Initial Authorization

1. Screening
2. ITP Meeting – develops list of MFP pre- and post-transition services needed and rationale
3. Research (pricing, availability) done by person & team to locate resources
4. Transition Coordinator completes Authorization form and sends to Fiscal Intermediary and DCH via FTP for identified needs

Rev. 07/10

5. Purchases made, services arranged
 - If contractor agrees to bill after discharge, TC Contractor does not issue payment up front (vendor finishing wheelchair ramp, peer supporter making pre/post visits, LTCO making post-discharge visits, etc.)
6. Discharge
 - TC has Vendor Request for Payment completed and signed by Vendor and submits along with applicable receipts/invoices to Fiscal Intermediary and DCH via FTP
 - Fiscal Intermediary requires a W-9 be submitted for each contractor – once per year unless information has changed
7. TC completes Vendor Import File and sends to Fiscal Intermediary and DCH via FTP
 - Outside Vendor name, Tax ID, and other info listed in the Vendor columns instead of TC CONTRACTOR
8. Fiscal Intermediary confirms that line items on Vendor Import File correspond to receipts and do not exceed authorized amounts or caps
9. Fiscal Intermediary issues payment to outside Vendor
10. Fiscal Intermediary issues invoice to MFP office at DCH (with subtotals for regular, enhanced, and admin fees)
11. MFP office adds all authorized/spent amounts for services to MFP manual tracking database
12. MFP office reviews Fiscal Intermediary invoice against Vendor Import File, supporting receipts, and authorizations to ensure caps and authorizations were not exceeded
13. MFP office authorizes DCH Finance to issue payment to Fiscal Intermediary via signoff
14. Fiscal Intermediary is paid
15. If TC purchased items that are not allowable or bills before discharge, process for recoupment is initiated internally at DCH

For TC Contractor Payment – Revised Authorizations

1. TC and participant determine that items or services not identified in the ITP are needed (item is damaged and needs replacement, health incident causes change in needs, etc.)
2. Research (pricing, availability) done by participant & team to locate resources
3. TC completes the *Request for Additional MFP Transition Services* form and submits to DCH MFP office via FTP
4. TC submits Revised authorization form (check “revised” on the form) and sends to Fiscal Intermediary and DCH via FTP for identified needs
5. Purchases made, services arranged
 - TC separates purchases for different individuals or different services onto separate receipts (i.e., household goods for person A separate receipt from furnishings for person A)
6. TC Contractor pays for items that require up-front payment
7. TC completes *Vendor Import File* and sends to Fiscal Intermediary and DCH along with receipts

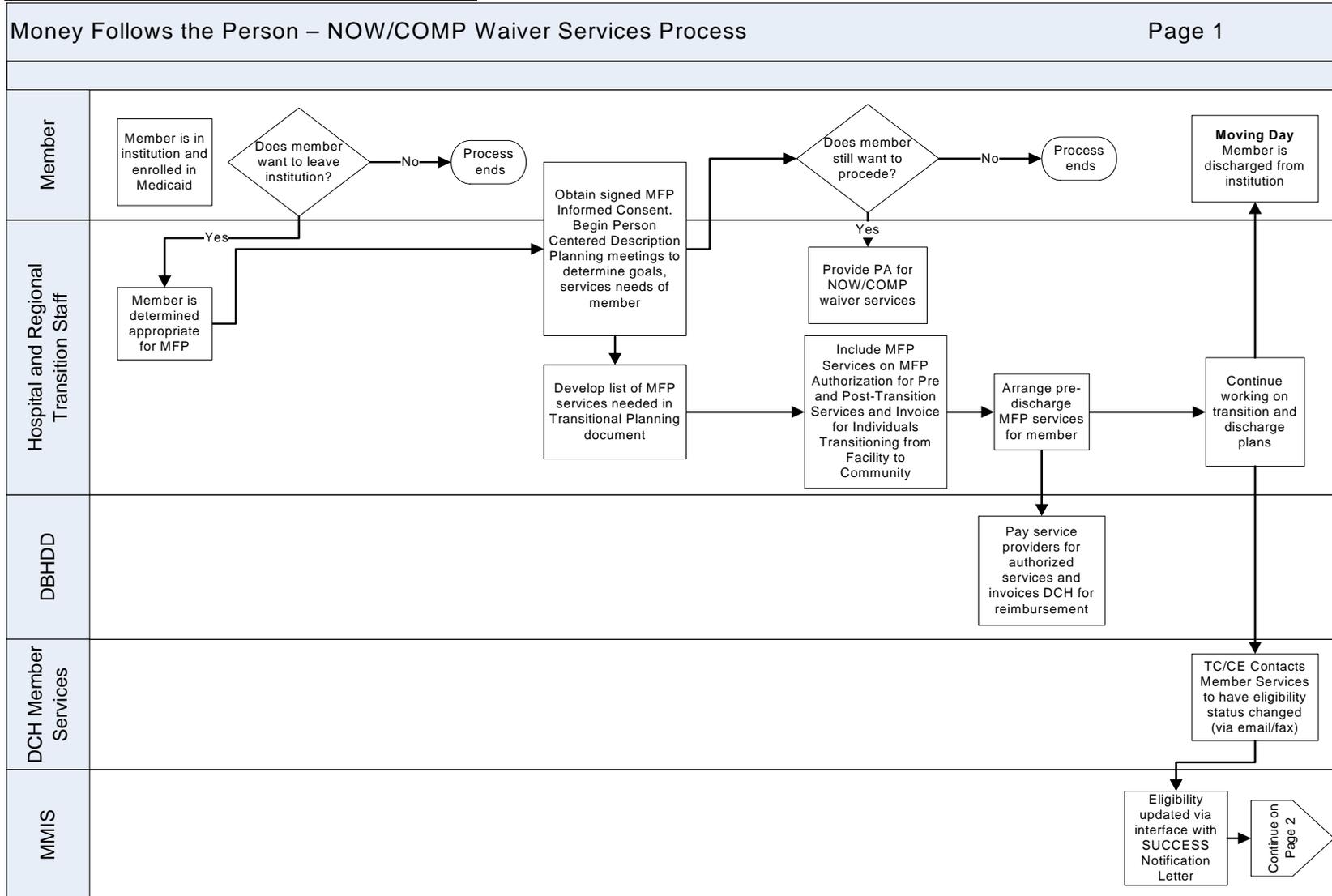
- TC notes name of individual on copy of receipt
8. Fiscal Intermediary confirms that line items on *Vendor Import File* correspond to receipts and do not exceed authorized amounts or caps
 9. Fiscal Intermediary issues payment to TC Contractor
 10. Fiscal Intermediary issues invoice to MFP office at DCH (with subtotals for regular, enhanced, and admin fees)
 11. MFP office adds all authorized/spent amounts for services to MFP manual tracking database
 12. MFP office reviews Fiscal Intermediary invoice against *Vendor Import File*, supporting receipts, and authorizations to ensure caps and authorizations were not exceeded
 13. MFP office authorizes DCH Finance to issue payment to Fiscal Intermediary via signoff
 14. Fiscal Intermediary is paid

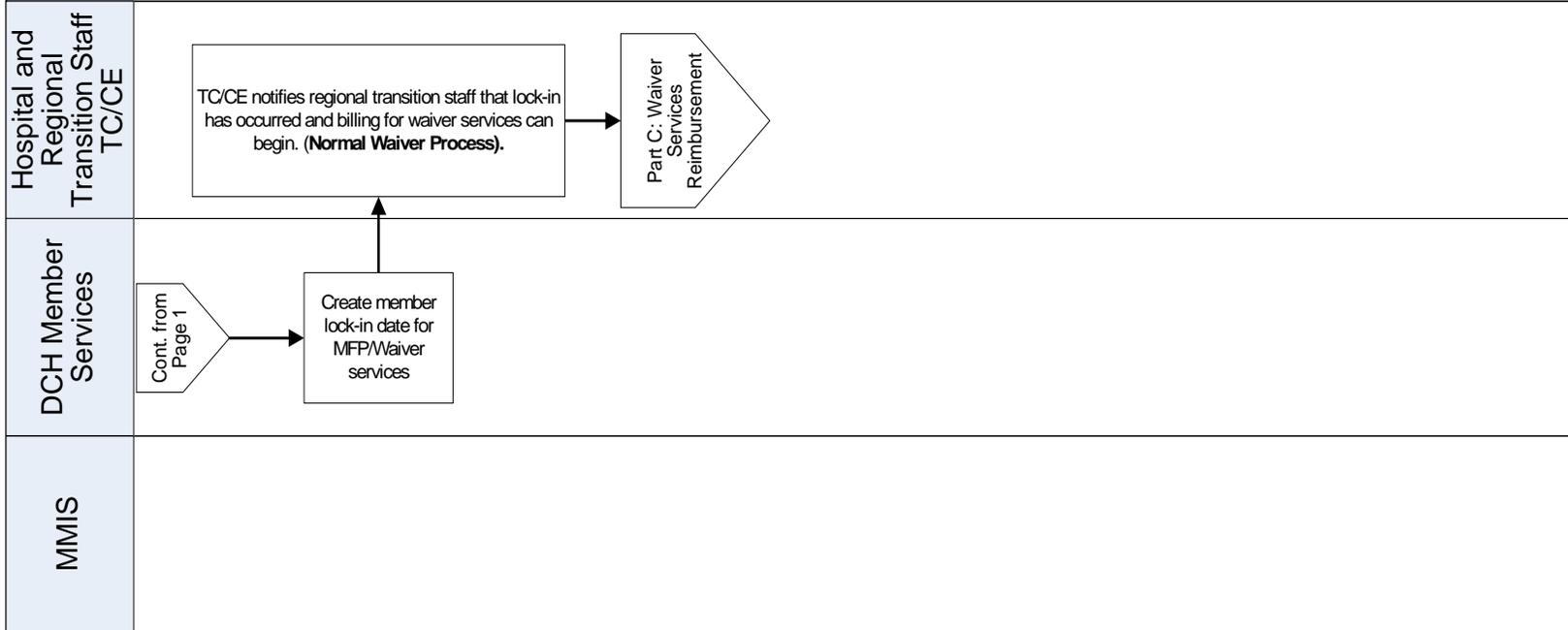
Rev. 07/10

For Outside Vendor Payment (TC Contractor, Peer Supporter, LTCO, etc.) – Revised Authorizations

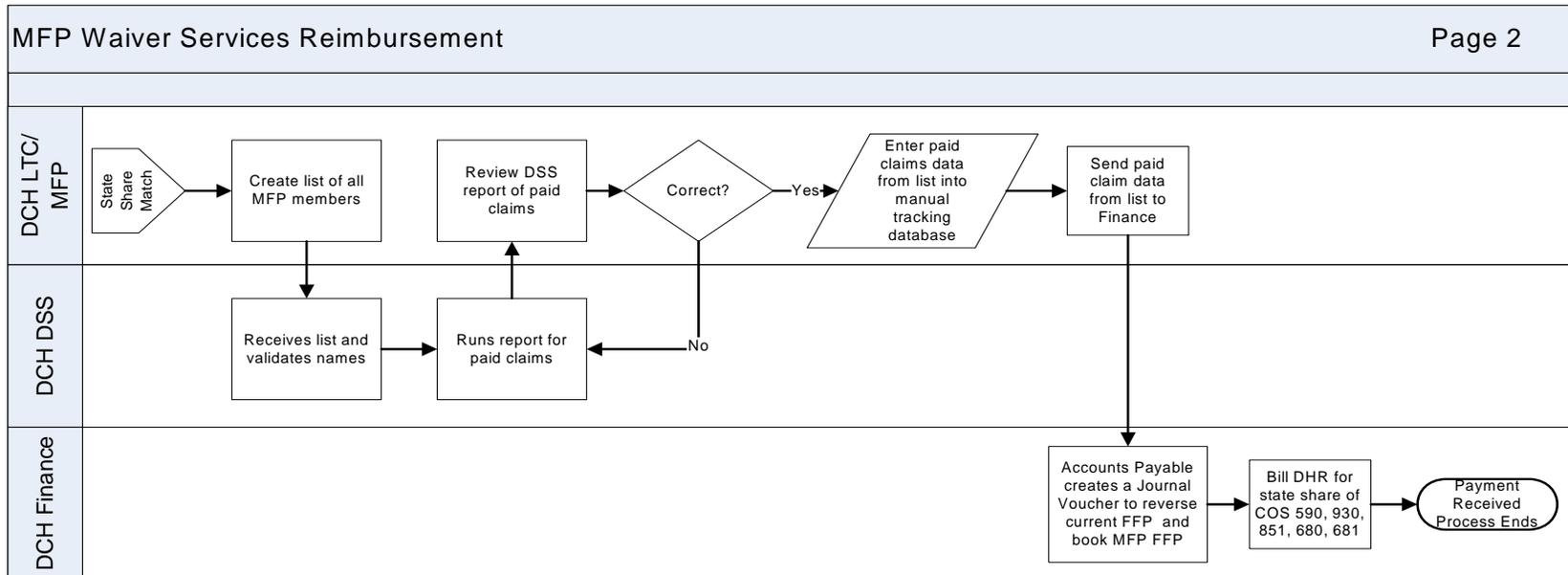
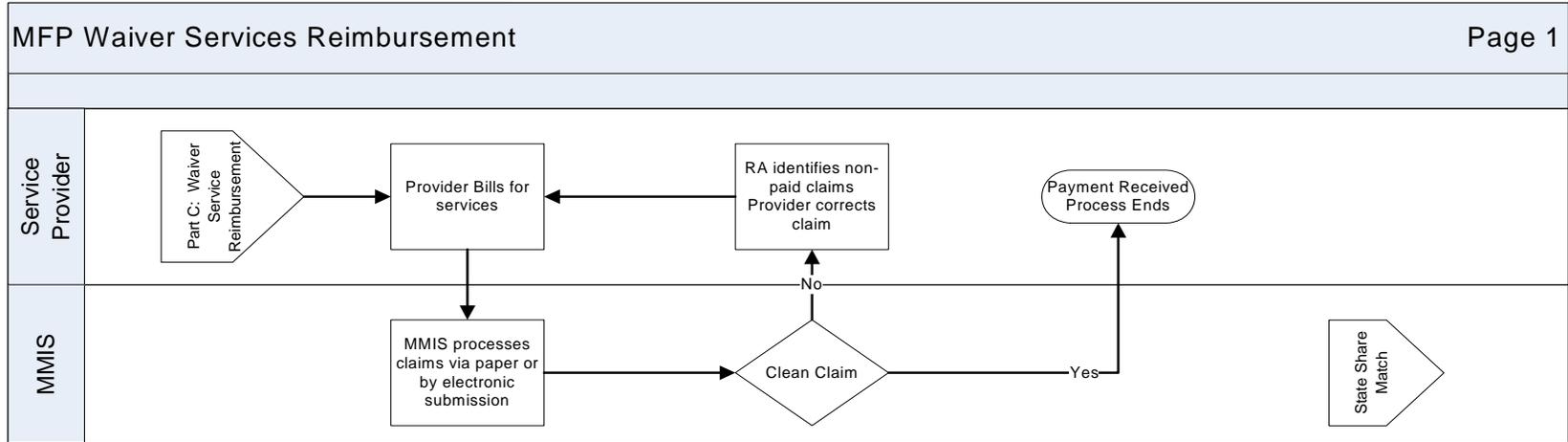
1. TC and member determine that items or services not identified in the ITP are needed (item is damaged and needs replacement, health incident causes change in needs, additional care giver training is needed, etc.)
2. Research (pricing, availability) done by participant & team to locate resources
3. TC completes the *Request for Additional MFP Transition Services* and submits to DCH MFP office via FTP
4. TC completes Revised authorization form and sends to Fiscal Intermediary and DCH via FTP for identified needs
5. Purchases made, services arranged
 - TC CONTRACTOR does not issue payment up front
6. TC has Vendor Request for Payment completed and signed by Vendor and submits along with applicable receipts/invoices to Fiscal Intermediary and DCH via FTP
7. Fiscal Intermediary requires a W-9 be submitted for each vendor – once per year unless information has changed
8. TC completes *Vendor Import File* and sends to Fiscal Intermediary and DCH via FTP
 - Outside Vendor name, Tax ID, and other info listed in the Vendor columns instead of TC CONTRACTOR
9. Fiscal Intermediary confirms that line items on *Vendor Import File* correspond to receipts and do not exceed authorized amounts or caps
10. Fiscal Intermediary issues payment to outside Vendor
11. Fiscal Intermediary issues invoice to MFP office at DCH (with subtotals for regular, enhanced, and admin fees)
12. MFP office adds all authorized/spent amounts for services to MFP manual tracking database
13. MFP office reviews Fiscal Intermediary invoice against *Vendor Import File*, supporting receipts, and authorizations to ensure caps and authorizations were not exceeded
14. MFP office authorizes DCH Finance to issue payment to Fiscal Intermediary via signoff
15. Fiscal Intermediary is paid

601.5 **NOW and COMP Waiver Services Process**





601.6 **DHS/DBHDD Reimbursement Process**



CHAPTER 602

ELIGIBILITY, RECRUITMENT AND ENROLLMENT

602.0 Introduction

This section describes MFP eligibility criteria, outreach and referral sources, recruitment, screening processes and screening tools. Waiver referral processes are reviewed. Procedures for how and when MFP participants are informed of their rights and responsibilities are reviewed. This section concludes with a description of the Quality of Life (QoL) survey and waiting list procedures.

602.1 MFP Eligibility Criteria

As provided for in the Deficit Reduction Act of 2005, MFP participants must meet the following eligibility requirements:

Rev. 07/10

1. Residing in an inpatient facility for at least 90 days--short-term rehabilitation stays of 90 days or less do not count
2. Receiving Medicaid benefits for facility services for at least one day (24 hour period) during the most recent month
3. Continue to meet institutional level of care

Further guidance on eligibility requirements and Medicaid payment

Rev. 07/10

A person must have resided in an inpatient facility for a minimum of 90 days (#1 above). There is a limitation to the 90 day eligibility policy--short-term rehabilitation stays will not count toward meeting MFP eligibility criteria. For example, if an individual enters a nursing facility for rehabilitation following surgery, and the stay is not intended to be a long-term, the stay will not count toward MFP eligibility. If the individual stays more than 90 days, the remainder of the stay beyond 90 days may be counted toward MFP eligibility criteria. Medicaid must have paid for the inpatient facility stay for at least one day (24 hour period) during the most current month (#2 above). Medicaid need not have paid for the entire 90 day stay. The participant needs to have received Medicaid for at least one day during their institutional stay. Participants who meet the minimum stay requirement (#1 above) and the Medicaid benefit requirement (#2), do not have to apply as a new Medicaid member and therefore do not have to wait another 90 days to qualify for MFP. The TC should also be aware that if a nursing facility resident has not yet applied for Medicaid, but meets the facility requirement for minimum stay (#1 above), the resident may apply for Medicaid and would only wait for one day to be eligible for MFP.

602.2 Outreach, Marketing and Education Strategies

The overall goal of current outreach, marketing and education is that all points-of-entry and information and referral networks provide accurate information about HCBS waiver programs and accurate information about MFP. To achieve this

goal, the focus is on developing systematic outreach through all points-of-entry and Information & Referral networks.

Outreach, marketing and educational presentations, booklets and informational brochures, public service announcements (PSAs) and information posts on the DCH, DBHDD, and DHS public websites are used to inform the community about home and community-based waiver services (HCBS) and the MFP Demonstration. Information about MFP and how it works has been added to already existing outreach, marketing, education and training undertaken by DCH. DCH Communications Services assisted MFP staff to prepare a press release, a flyer, a brochure (see *Appendix C: MFP Tri-Fold Recruiting Brochure*), color poster, postcards/handbills and a *Participant Transition Planning Guide* about MFP. TCs can use approved recruiting text for MFP to create other outreach, marketing and recruiting materials. Such materials must be approved by DCH, MFP Project Director. Outreach information about MFP was added to existing DCH Medicaid Division, Office of Long Term Care outreach materials (see *Appendix E: How To Obtain the Booklet, Home and Community Services, A Guide to Medicaid Services in Georgia*), web pages and fact sheets. Partners in the Department of Human Resources are promoting MFP through similar channels.

Rev. 07/10

MFP Targeted Outreach and Marketing

Targeted outreach is ongoing through a variety of methods, including, face-to-face communication, relationship building, presentations, informational forums and distribution of outreach materials at interagency meetings, MFP quarterly steering committee meetings and training presentations. Written materials are available in plain English for better understanding for persons with cognitive impairments. Materials can be translated into Spanish and French (or other languages as provided by DHS's Limited English Proficiency and Sensory Impaired Customer Services Office), and materials are being made available in alternative formats for individuals who are blind, low-vision, deaf and/or hard-of-hearing.

Efforts focus on providing information about MFP along with information about all HCBS waiver services and options. MFP is being marketed to a broad range of entities. Outreach, marketing and education are targeted to:

- Professional Associations of hospital and facility/institutional discharge planners, social workers and rehabilitation hospitals,
- CIL networks, advocacy organizations including People First of Georgia, Georgia Advocacy Office and Atlanta Legal Aid Society and caregiver support groups,
- Georgia peer support networks,
- Point-of-entry systems, AAAs, ADRCs, ATRC/Tools for Life, waiver and other community based service providers who provide information and referral to all HCBS waivers,

- Professionals doing members' eligibility determination
- Selective physician offices, crisis intervention services,
- Long-Term Care Ombudsman staff and volunteers, and
- Senior Centers, Meals on Wheels, and Community Mental Health Centers.

Role of TCs in MFP Targeted Outreach and Marketing to Older Adults and Persons with Physical Disabilities and/or Acquired brain injury (ABI)

TCs engage in outreach to older adults in nursing facilities across the state. MFP TCs partner with DHS Division of Aging Services Area Agencies on Aging (AAA/Gateway Network) including the Aging and Disability Resource Centers (ADRCs), waiver case manager entities, provider associations, Long Term Care Ombudsman, nursing home discharge planners/social workers, nursing home resident councils, advocates and other points-of-entry to solicit and receive referrals for older adults who may be eligible for MFP. Eligible older adults enter CCSP or SOURCE Programs.

TCs engage in outreach to participants with physical disabilities and Acquired brain injury (ABI) in nursing facilities in all areas of the state. MFP TCs are expected to actively reach out to ADRCs, Georgia Centers for Independent Living (CILs), Georgia Medical Care Foundation (the assessment entity for the ICWP waiver), the ICWP provider network, the Brain and Spinal Injury Trust Fund Commission, and regional and local service provider networks to market MFP and solicit, obtain and work referrals. MFP TCs screen participants with physical disabilities/ABI for the ICWP waiver statewide.

Outreach efforts overlap for older adults and people with physical disabilities. Under the terms of the current contract, TCs provide services to both older adults and people with physical disabilities and ABI. Qualified nursing facility residents with physical disabilities can be referred to either the ICWP or to the Elderly and Disabled waivers (CCSP and SOURCE), depending on need and waiver slot availability.

602.3 Recruiting

MFP TCs recruit older adults and people with physical disabilities statewide for the Elderly and Disabled Waiver Programs (CCSP and SOURCE) and/or the Independent Care Waiver Program (ICWP), depending on need and waiver slot availability. MFP Case Expeditors within DBHDD will recruit individuals located in ICFs throughout the State for NOW and COMP.

TCs use (but are not limited to) the following strategies to recruit MFP participants:

- Ask for and work referrals from point-of-entry systems,
- Ask for and work referrals from participants, family members, care givers, or guardians,

- Make initial contact with nursing facility residents,
- Observe and visit persons in institutional settings and provide these persons with MFP outreach materials and contact information,
- Conduct face-to-face interviews with participants, family/friends/circles of support and discharge planners (social workers and/or NF administrators)
- Make outreach efforts, providing information about MFP (see *Appendix C: MFP Tri-Fold Recruiting Brochure*) and information about HCBS waivers and community resources (see *Appendix E: How to Obtain the Booklet, Home and Community Services; A Guide to Medicaid Services in Georgia*),

Initial Meeting with Potential MFP Participants

TCs should pay particular attention to the first visit with potential MFP participants and nursing facility (NF) staff. Make initial visits face-to-face. On the first visit, don't take forms. To establish rapport with the person, be informal. Make small talk. Introduce yourself and tell the person that the purpose of your visit is to provide information about a new opportunity that may or may not be of interest to the nursing home residents. Ask where the person is from and tell the person where you are from. Ask the person where s/he grew up, attended school and where their people are now living. Be informal and casual when describing MFP. Provide the person with MFP outreach and marketing materials (the recruiting brochure) and contact information.

Be prepared for some resistance from some NF staff members. Think about and prepare to answer objections, including, “_____ (person) doesn't want to leave,” “no, _____ (person) can't come to the phone,” “you must sign _____ (person) out.”

If the NF resident appears interested in learning more about MFP, find out whether the person has a guardian. Include the guardian in future meetings with potential MFP participants. If the person doesn't have a guardian, schedule a follow-up visit with the person to complete the informed consent, release of information and the MFP Screening Form.

602.4 Participant Consent, Rights and Responsibilities

TCs obtain signed informed consent from each participant (or guardian, as appropriate) using the *MFP Consent for Participation* (see Appendix D2). TCs obtain permission from each participant (or guardian as appropriate) for the release of all records that exist within the nursing/ institutional facility for review by obtaining the participant's signature on the *Authorization for Use or Disclosure of Health Information* (see Appendix D1).

During the informed consent process, TCs are required to provide a copy of the booklet, *HCBS, A Guide to Medicaid Waiver Programs in Georgia* (see Appendix

E). TCs are expected to be familiar with the booklet and to review the information with the participant. TCs must verbally read to the participant the section in the booklet, *Your Rights and Responsibilities* and discuss the section with the participant. TCs must verbally read the *MFP Consent for Participation* to the participant and discuss it with the participant. Prior to obtaining the participant's signature on the consent form, the TCs field participant's questions and discuss confidentiality of Personal Health Information (PHI). The participant must be told that participation is voluntary and can be withdrawn at anytime. The participant must be told that MFP services are available for 365 calendar days and that waiver services will continue after the end of MFP as long as the participant continues to need waiver services.

The consent and release of information must be signed before the screening can begin. After the consent is signed, the person is considered to be an MFP participant, although the participant's 365 calendar days (MFP Lock-in Span) of services will not begin until the day of discharge.

602.5 Working with Guardians

Once potential MFP participants have received information about MFP and have indicated interest in MFP/transitioning, TCs obtain consent and release of information to determine if the participant has a guardian. TCs must obtain copies of these legal document(s) and review them to establish the extent of the surrogate decision making power that exists. In cases where the guardian is viable, TCs must obtain informed consent and release of information from the participant's guardian. During subsequent development of *Individualized Transition Plans* (see *Appendix Q1 and Q2*), TCs must involve participants, family members/friends, caregivers and guardians in person-directed planning and circles of support.

Involving Guardians in Informed Consent

TCs are expected to use various strategies to inform potential MFP participants, family members, friends and/or guardians about MFP, including: providing outreach and marketing information, providing opportunities to discuss MFP options and services before signing the *Authorization for Release of Information and Informed Consent Form* (see *Appendix D1 and D2*), and providing opportunities to discuss traditional waiver options and MFP transitional services with the waiver case manager during waiver assessment.

TCs must provide institutionalized persons, family members, caregivers, friends and/or guardians with easy to use, understandable information, or information in alternative formats about MFP and core waiver services, eligibility criteria, how to apply and what to expect. Information about MFP is provided along with core waiver services through statewide Point-of-Entry partners including: AAA/Gateway networks, Aging and Disability Resource Centers (ADRCs), Centers for Independent Living (CILs), provider networks, and regional Mental

Health, Developmental Disability and Addictive Disease (MHDDAD) regional service councils and providers. TCs must give potential MFP candidates opportunities to receive and discuss information about MFP during face-to-face interviews and follow-up meetings.

Working with waiver case managers (CMs), TCs will identify current waiver participants who have successfully resettled in the community and who have guardians. TCs will ask these guardians, if interested, to visit with guardians of institutionalized persons considering transition under MFP. Visits with guardians of successfully resettled waiver participants will help guardians considering transition to understand and weigh both the benefits and risks of resettlement. Discussions between guardians, participants, TCs and CMs may be enough to move the process forward. If not, LTC Ombudsmen will be called in to assist at the request of the participant. For example, if a person in a nursing home indicates interest in resettlement in the community, but the guardian is opposed and will not allow the process to move forward, LTC Ombudsmen may be asked to intervene. LTC Ombudsmen educate guardians about the participant's Bill of Rights and when necessary, can refer the participant/consumer to free legal assistance (i.e. Atlanta Legal Aid Society) for additional legal help to reverse guardianship. On the other hand, if any member of the transition team believes that a participant/consumer is actually opposed to community placement, but the participant's guardian is for such a placement, the LTC Ombudsman may be asked to intervene for the purpose of working with the guardian regarding the participant's preference to continue institutional placement and educating the guardian about the limits of guardianship.

Following waiver enrollment and resettlement to the community, TCs visit with participants, family members, caregivers and guardian to ensure that participants are receiving all MFP and traditional waiver services as specified in the service plan. When resettled participants have guardians, TCs follow-up with the guardian to answer any questions and/or provide additional information about grievance and complaint processes. TCs are expected to leave their contact information and the contact information for waiver case managers and ask guardians to call with questions or if problems arise.

602.6 Screening Potential MFP Participants

TCs perform transition screenings to assess nursing facility residents for the MFP demonstration. TCs refer eligible participants to CCSP, SOURCE and ICWP waivers. MFP Case Expeditors perform the same functions in ICFs, screening residents for transition using NOW and COMP, under the DCH/DBHDD Interagency Agreement. During the screening process, TCs explore with MFP participants the following:

- Participant's rights and responsibilities,
- background--how the participant come to be at the NF,

- the interest the person has in returning home or to the community,
- the type of qualified housing the person is interested in,
- resources they have that can help them return home or to their community successfully, help from family, friends and/or care givers,
- health care, assistive technology, durable medical equipment and functional needs for assistance,
- documentation needed to resettle,
- concerns, fears and barriers to a successful relocation to the community and what can be done to relieve fears and remove barriers,
- MFP services, options for long-term waiver services and supports, State plan services and local community services that can help the participant successfully resettle,
- Other issues that may need to be explored.

During the screening process, TCs are responsible for the following:

1. completion of the MFP screening tool (see *Appendix G: MFP Transition Screening Form*), to build a personal profile of each MFP participant that includes medical, financial, functional and psychosocial information, needs for housing, services and items necessary to establish a community-based residence,
2. assistance in securing personal identification documents as needed for screening, Medicaid eligibility, housing, transportation, etc.,
3. involving family/friends/care givers and guardians (as appropriate),
4. facilitating referrals to the appropriate waiver(s), assisting participants to prepare for these assessments,
5. assisting participants to complete an application for waiver services,
6. matching participant needs to MFP pre and post-transition services
7. matching participant needs to HCBS waiver services and community resources (DME/Complex Rehab Equipment Specialists, Assistive Technology Specialists at ATRC/Tools for Life, etc.), ensuring effective use of MFP transition funds first, followed by waiver funds, when both types of funding are available for services,
8. educating and informing participants about self-direction options under waiver programs,
9. collaborating with the waiver case managers to ensure the waiver assessment is completed,
10. linking participants to peer supporters and authorizing peer support as a pre-transition service (using CILs and the Peer Support Network) who have successfully resettled in the community,

Rev. 07/10

Rev. 07/10

11. arranging for pre-transition services, including one or more overnight stays, to allow MFP participants to gain knowledge and understanding about independent living,
12. assisting the participant to locate and arrange for qualified housing and/or rental assistance programs, obtaining quotes for needed environmental modifications,
13. assisting the participant to access local public and private transportation resources,
14. clarifying which transition services will be provided and funded through MFP and which services are the responsibility of the waiver service provider and which are the responsibility of the participant/family/circle-of-support.

602.7 Referral Sources

There are a number of sources from which MFP TCs receive referrals and to which TC make referrals. Referrals come from point-of-entry networks, from participants, family members, care givers, from guardians, from nursing facility staff and resident councils, from hospital and rehab center discharge planners, from partnering agencies and organizations and from wavier case mangers.. When referrals have been checked, TCs then schedule and complete the MFP screening in a face-to-face interview. Once MFP candidates have completed and signed the informed consent and the health information release (see *Appendix D1 and D2*), TCs complete the *MFP Transition Screening Form* (see *Appendix G*). Once the screening is completed with supporting documentation, TCs make referrals to an appropriate waiver for waiver screening and assessment.

Referrals to CCSP (Community Care Services Program)

To refer to CCSP, contact the Area Agency of Aging serving the area where the MFP participant will transition (see *Appendix F: AAA Gateway Network*).

Referrals to SOURCE (Service Options Using Resources in Community Environments)

To refer to SOURCE, contact the number listed for the program serving the county where the participant will transition. For a complete listing of SOURCE providers, see *Appendix I: SOURCE Providers*.

Referrals to ICWP (Independent Care Waiver Program)

To refer to ICWP, contact the Georgia Medical Care Foundation (GMCF) at 1-800-982-0411 or 678-527-0319.

Further Guidance on Referrals of MFP Participants on ICWP Waiting Lists

When TCs refer MFP participants to GMCF who are already on the ICWP waiting list, GMCF does not conduct a reassessment on the MFP participant

unless there has been a major change in the participant's health status since the date of their original assessment. It is very important that TCs communicate screening information to GMCF upon making the referral, so that GMCF can take the necessary steps to schedule a reassessment, when necessary. TCs obtain health information during the screening and through their review of the nursing facility resident records. TCs use the following process when referring a MFP participant already on the ICWP waiting list to GMCF for waiver assessment:

- 1) The TC sends a copy of the screening documentation to GMCF.
- 2) Once the MFP participant is approved for ICWP, GMCF's point person for MFP emails a copy of the approval letter to the MFP participant's TC.
- 3) The TC helps the participant select a case manager and begins the usual transition process once the participant received his/her ICWP waiver acceptance letter.
- 4) If the MFP participant does not respond and select a case manager within the allotted two weeks, GMCF will issue another letter, with a copy to the TC.
- 5) Once a case manager is selected by the MFP participant, the process continues with person-directed planning facilitated by the TC and the development of the Individualized Transition Plan (ITP) (see Appendix Q1 and Q2).
- 6) If changes in health status have occurred since the last assessment, the MFP participant will need to be reassessed by GMCF.

Further Guidance on Referrals from Non-Participating CCSP Areas

TCs should be aware that they will receive referrals from non-participating CCSP areas of the state. If the TC receives and qualifies a referral from any of these nine areas of the state, the TC should work the referral as per normal protocol, including making the referral for waiver assessment via the telephone screening done by the appropriate AAA/Gateway office. There should be no difference in the manner in which the referral is worked by the TC. In the three CCSP participating areas (ARC, CSRA, and NWGA), TC will involve CCSP Care Coordinators in the transition planning process. The Care Coordinators will provide post-transition follow-up. In the other nine areas of the state, MFP participants can access CCSP MFP slots, but they will not receive additional assistance from CCSP Care Coordinators during the pre-transition planning process. The TC should not expect CCSP Care Coordinators in these nine areas to participate in transition planning. Normal waiver referral processes apply—the MFP participant will be assessed for CCSP in the nursing facility and treated as a typical CCSP referral. For these participants, the TC should assist with the change from nursing facility Medicaid to CCSP Medicaid and verify that the Level of Care (LOC) is signed, so that CCSP services can begin on the day of discharge or as soon as possible thereafter.

Referrals to the New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program (COMP)

Rev. 07/10

TCs refer persons with developmental disabilities to the Department of Behavioral Health and Developmental Disabilities Regional Office for the area where the MFP participant resides:

- Region 1 DBHDD Regional Office (Rome) 706-802-5272
- Region 2 DBHDD Regional Office (Augusta) 706-792-7733
- Region 3 DBHDD Regional Office (Tucker) 770-414-3052
- Region 4 DBHDD Regional Office (Thomasville) 229-225-5099
- Region 5 DBHDD Regional Office (Savannah) 912-303-1670

Further Guidance on Referrals of Persons with Developmental Disabilities

As they recruit, TCs may encounter people with developmental disabilities residing in nursing facilities around the state. These people may be qualified to resettle to the community using the NOW and COMP waivers, waivers managed by DBHDD. When individuals with developmental disabilities are encountered in nursing facilities, TCs should make a referral to the Regional DBHDD office and be prepared to assist case expeditors and other Regional office staff with information. Typically, Regional DBHDD staff and case expeditors will transition these individuals using existing mechanisms and processes. TCs have no transition goals related to persons with developmental disabilities and will not be paid to make transitions into NOW/COMP.

Referrals from Georgia State Psychiatric Hospitals

Medicaid does not cover the services in an institution for mental disease (IMD). An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care of individuals with mental diseases, whether or not it is licensed as such. An Intermediate Care Facility (ICF) for persons with developmental disabilities (DD) is not an institution for mental diseases. To be eligible for MFP, participants must meet all the following criteria:

Rev. 07/10

Rev. 07/10

1. Reside in an inpatient facility for at least 90 days--short-term rehabilitation stays of 90 days or less do not count
2. Receive Medicaid benefits for facility services for at least one day (24 hour period) during the most recent month
3. Continue to meet institutional level of care

These eligibility criteria prohibit persons in the state's psychiatric hospitals from accessing MFP.

602.8 Quality of Life Survey

The Quality of Life survey is being conducted to help the Centers for Medicare and Medicaid Services (CMS) and the Georgia DCH Office of Long Term Care

understand the perspectives and experiences of MFP participants as they resettle in the community. The MFP TC will receive training on conducting the QoL survey and must complete the survey face-to-face with the MFP participant 30 days to two weeks before discharge from the nursing facility. An independent agency under contract with DCH will conduct the 2nd and 3rd administrations of the QOL survey. The 2nd QOL survey will be conducted at 12 months post-discharge. The TC will arrange for a surveyor to complete the QOL survey during the 12th month of the participant's community placement. The surveyor will contact the TC and the MFP participant make arrangements to complete the follow-up survey either face to face or by telephone. The 3rd QOL survey will be conducted by agency surveyors at 24 months post-discharge.

602.9 Waiting List for MFP Services

Funding for the MFP program is limited. There are a limited number of 'slots' of reserved capacity in each waiver. Therefore, only a certain number of participants receive services based on available funds. When reserved waiver capacity is exceeded, MFP uses a 'first-come-first-served' approach to service delivery. The date of the initial MFP screening will be used to prioritize the MFP waiting list. This date can be found on the first page of the MFP Transition Screening Form (see *Appendix G: MFP Transition Screening Form*). An MFP participant will be selected from the waiting list, based on length of time on the waiting list. With regard to waiver waiting lists, the State will amend the MFP Operational Protocol to reflect the Olmstead agreement, as these protocols are developed and implemented.

CHAPTER 603

PARTICIPANT ASSURANCES

603.0 Introduction

MFP participants receive the same assurances as all waiver participants with regards to: 1) level of care determinations, 2) service plans, 3) identification of qualified providers, 4) participant health and welfare, 5) waiver administrative oversight, 6) 24/7 emergency backup systems, 7) grievance/complaint systems, and 8) critical incident reporting systems. MFP Transition Coordinators (TCs) will assist in the development, monitoring and improvement of the 24/7 emergency backup system, the grievance/ complaint system and the critical incident reporting system.

This section provides guidance on ensuring the MFP participant's health, safety and welfare during and after the 365 day MFP transition period. The development, monitoring and improvement of the 24/7 emergency backup system, the grievance/complaint system and the critical incident reporting system are described. Roles and responsibilities of the MFP TC are identified. Remedies for quality problems experienced by MFP participants are reviewed. This section concludes with a description of the MFP critical incident procedures, the entities responsible for receiving and reviewing critical incident reports, responding to problems concerning complaints and critical events and investigating participant complaints regarding violations of participant rights.

603.1 Ensuring Health, Safety and Welfare

MFP Transition Coordinators (TCs) ensure health, safety and welfare of participants by informing participants of options and responsibilities, by providing transition services and monitoring these services to ensure successful placement in the community. TCs inform participants of the right to be free from mental, verbal, sexual, and physical abuse, neglect, exploitation, isolation and corporal or unusual punishment and how complaints and/or concerns are reported.

To ensure participant health, safety and welfare, MFP TCs provide justifications for MFP pre-and post-transition services. Justifications that meet this standard are documented in the Individualized Transition Plan (see *Appendix Q1*). TCs authorize the purchase of products and services, when these purchases are justified to meet participant health, safety and welfare needs. TCs use the *Authorization for MFP Services* (see *Appendix S*) for this purpose. On the other hand, TCs do not justify purchases for entertainment or recreation purposes. For example, if the participant doesn't have a TV, but desires one for entertainment, the TCs would not authorize the purchase of a TV because the expressed use of the TV is for entertainment. The TC exercises discretion in the purchase of goods and services. Justifications for authorized goods and services are based on

ensuring the health, safety and welfare of the MFP participant.

In addition to services justifications, TCs ensure participant health, safety and welfare through the development, monitoring and improvement of the 24/7 emergency backup system, the grievance/ complaint system and the critical incident reporting system. TCs collaborate with waiver case managers to ensure that these systems are in place and functioning correctly.

603.2 24/7 Emergency Backup Plans

The 24/7 emergency backup system serves MFP participants through existing HCBS waivers. Emergency backup systems are unique to each waiver, but include common elements. TCs assist each MFP participant to identify risks to health, safety and welfare. Risks to health, safety and welfare are documented in the ITP (see Appendix Q1). TCs develop plans for mitigating these risks. For each risk identified, a plan for services and supports is developed and written in the ITP. TCs assist participants in planning for and developing 24/7 emergency backup plans. Together with waiver case managers and MFP participants, TCs assist with the implementation monitoring and improvement of these 24/7 emergency backup plans.

In all waivers, information from the initial assessment or reassessments is used to identify risks to waiver participant health and safety. Each identified risk is included in the service plan with individualized contingency plans for emergency back-up.

Participants are provided with 24/7 emergency phone contacts for their MFP TC, their waiver case manager and for their service providers. Vendors/agencies are required to provide 24/7 backup for direct care staff and to instruct direct care staff on participant needs and preferences. Participants utilizing participant-directed options must identify at least two individuals (i.e. friends, family members, etc) in their emergency plans to assist them in the event that provider staff doesn't show up. The service plan includes plans for equipment failures, transportation failures, natural disasters, power outages, and interruptions in routine care. For providers agencies, 24/7 on-call backup is mandated.

In addition, some MFP participants receive an Emergency Response Services (ERS) system. The ERS system monitors participant's safety and provides access to 24/7 emergency intervention for a medical or environmental crisis. The ERS is connected to the participant's telephone and programmed to signal a response once activated from a device that is worn or attached to the participant. ERS home units are programmed to dial a toll-free number to access a central monitoring station. Monthly testing of the ERS is undertaken by ERS providers and a battery backup is provided.

Case management agencies document all emergencies. Waiver case managers

triage each incident and request additional emergency response, if needed. When there is an immediate threat to the health, safety and/or welfare of the participant, case managers may immediately (within 24 hours) relocate the MFP participant to another setting.

TCs should be aware that when an MFP participant utilizes the 24/7 emergency backup system, this is reported to waiver program manager in the appropriate waiver operating agency (DCH, DHS, or DBHDD). The waiver program managers will forward these monthly reports to the MFP Project Director. The MFP Project Director will discuss this utilization with the MFP TC. Once the TC becomes aware that the MFP participant has used the 24/7 emergency backup, the TC should follow-up with the participant to see how her/his MFP services are working and if additional MFP transition services are needed to reduce or prevent the use of the 24/7 emergency backup system.

For the MFP participant, the TC asks the following regarding the 24/7 emergency backup system:

- Are systems tailored to the needs of the participant (different by disability)?
- Is the system in place on the day of discharge?
- Does the MFP participant know who to call based on the type of emergency experienced?
- How will the TC know that the participant understands how to use the system?
- Is the system in place for all critical health or supportive services and providers for MFP transition services and for waiver services?
- What will responsible entities do to fill in for services needed to prevent endangering the MFP participants' health, safety and welfare (this must be more than providing the participant with a phone number that simply refers the participant to local 9-1-1)?
- How will the system be monitored and improved?
- How and when will information on utilization be shared with the TC?
- How will TCs respond to utilization reports?
- How will the TC measure the outcome of authorizing additional MFP services on the utilization of the system?

Emergency Backup Plan for MFP Contracted Services

For contracted services (i.e. Peer Community Support, Trial Visit-Personal Support Services, Contracted Moving Service, Roommate Match Services, Transportation, Skilled Out-of-Home Respite, Environmental Modifications, Vehicle Adaptations, etc.), the MFP TC recruits vendors, agencies and/or contractors to provide these services. Each needed service is included in the participant's Individualized Transition Plan (ITP) and authorized using the *MFP Authorization for Transition Services* (see Appendix S). Contingencies for emergency backup are included in the transition plan. If the vendor, agency or contractor cannot provide a scheduled service to the MFP participant, the vendor,

agency or contractor is required to call the participant and try to reschedule the service with the participant. If that is not satisfactory to the participant, the vendor, agency or contractor will offer a back-up service for the originally scheduled service. In addition to arranging alternatives with the MFP participant, the vendor, agency or contractor is expected to contact the Transition Coordinator with this information.

Emergency Backup Plan for MFP Fee-For-Services

Fee-for-service purchases (i.e. Household Furnishings, Household Goods and Supplies, Moving Expenses, Utility and Security Deposits, etc.) are made through the Fiscal Intermediary. One-time goods and/or services needed by the MFP participant are justified during the development of the transition plan. The TC includes needed goods and/or services in the Individualized Transition Plan (ITP) and authorizes these services using the *MFP Authorization for MFP Services* (see Appendix S). The participant and TC work together to locate and determine the cost of the goods and/or services. The TC authorizes the purchase of the goods and/or services and provides the documentation that justifies how they meet the transition goals in the transition plan. The TC obtains and delivers the goods/services and transmits the invoice information to the Fiscal Intermediary using the *Vendor Import File* (see Appendix V). A paid invoice or receipt that provides clear evidence of the purchase must be kept with the participant's transition plan to support all goods and/or services purchased along with the *Vendor Payment Request to TC* (see Appendix U). The Fiscal Intermediary also tracks the purchases. If a vendor fails to provide the purchased goods and/or services, the TC is responsible for canceling the transaction and/or obtaining a refund from the vendor. The TC and MFP participant must locate another vendor willing to supply the goods and/or services.

603.3 Complaints Process and Critical Incident/Sentinel Event Reports

TCs notify the MFP Office when a "sentinel event" has occurred with an MFP participant. This is part of the Critical Incident Reporting process. While most MFP participants are enrolled in a HCBS waiver and have a waiver case manager and/or providers who act on complaints and critical incidents, it is necessary that MFP Project Officers receive such notification from TCs. This is especially important for MFP participants that may not be on a waiver or who experience a critical incident that is directly related to their MFP participation, before they have transitioned into the waiver. For example, TCs are expected to report on critical events including hospital admission following an MFP trial home visit. TCs use the *MFP Sentinel Event Report* (see Appendix AB) to report sentinel events including hospitalizations, injuries, abuse/neglect/exploitation, law enforcement incidents, etc., for MFP participants. An MFP participant is defined as a participant who has signed the MFP Consent for Participation. TCs notify the MFP Project Officers within 24 hours of the incident (discovery of the incident) by faxing the completed form to DCH MFP Office (fax: 866-883-7990).

TCs are required to do the following in response to critical incidents/sentinel events experienced by MFP participants:

- Call 9-1-1 or other emergency numbers to obtain immediate medical or law enforcement interventions if needed
- Obtain immediate and ongoing medical intervention if required
- Immediately implement measures to protect the health, safety and/or rights of the individual, including relocation of the participant to another facility or program if needed
- As appropriate, notify the family, guardian, next of kin, or emergency contact indicated in the participant service record
- Report the incident to the waiver operating agency (DCH, DHS, or DBHDD)
- Investigate the incident as applicable
- As appropriate, notify the Long Term Care Ombudsman (888-454-5826)
- Prepare a written report of the findings of the investigation using the *MFP Sentinel Event Report* (see *Appendix AB*) for each event and forward the completed document to the MFP Project Director, who will investigate the event and take appropriate corrective action
- As appropriate, report the incident to licensure and/or certification agencies, Adult Protective Services (888-754-0152), Child Protective Services (report to the DFCS office in the county where the child lives), local law enforcement agencies (check the phone book blue pages), and DCH Program Integrity (for example, if the MFP participant is living in a personal care home or community living arrangement, report any abuse, neglect or exploitation to the DCH Healthcare Facility Regulation Division at 404-657-5700)
- Submit a written plan of action, as requested by the MFP Project Director
- As needed, assist with on-site inspection of the facility/program to assure the plan of action is implemented
- Analyze incident data from Sentinel Events and complaints provided by the MFP Project Director to identify systemic changes needed to prevent recurrences. Make recommendations for revisions to state Medicaid and MFP policies and procedures

Rev. 07/10

CCSP is operated jointly by DHS/DAS and DCH. DHS/DAS is responsible for overseeing the reporting of and response to critical events and reports these to DCH. The NOW and COMP waivers are operated jointly by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and DCH. DBHDD and DCH share the responsibility for overseeing the reporting of and response to critical events. For the SOURCE and ICWP waivers, DCH is responsible for overseeing the reporting of and response to critical events.

603.4 Participant Denial or Termination from MFP

Potential MFP participants can be denied enrollment in MFP if they are found to be ineligible for the program. The eligibility requirements for MFP were set forth in the Federal Deficit Reduction Act of 2005 as amended, and are:

Rev. 07/10

1. Individual must have resided in an inpatient facility for at least 90 days-- short-term rehabilitation stays of 90 days or less do not count
2. Individual must have received Medicaid benefits for facility services for at least one day (24 hour period) during the most recent month
3. Individual must continue to meet institutional level of care, but the individual does not require the level of care provided by an inpatient facility.

MFP participants can be determined no longer eligible to participate in the MFP demonstration. The major criteria for participating in the MFP demonstration are set forth by the Federal Deficit Reduction Act of 2005 as amended, and are:

1. Participant must be Medicaid eligible.
2. Participant must transition from the inpatient facility into a qualified residence (refer to Section 605.1 for a full definition of qualified residences).
3. Participant must continue to meet institutional level of care criteria.

In addition, participants may also be determined ineligible for MFP if they inform their TC that they no longer wish to participate in the program or if they elect to move outside of the service area for the State of Georgia.

MFP participants may receive Medicaid HCBS waiver services. These services are funded by the MFP grant during the 365 day demonstration period, and therefore participants may lose their waiver services if they become ineligible for MFP during the year of the demonstration.

TCs are responsible for the following regarding MFP denial and terminations:

- Issue denial notices (see *Appendix AC: Notice of Denial or Termination from the MFP Program*) to participants including administrative hearing rights available for denial of eligibility or termination of service.
- Maintain appropriate documentation of decision-making for administrative review and appeals

603.5 Appeal Process and Administrative Review

If an MFP participant or potential participant receives notice that they are ineligible or will be terminated from the MFP Demonstration, and they disagree with this decision, they may request a fair hearing. The request for a hearing must be received by the Department of Community Health within 30 calendar days

from the date of the Notice of Denial letter.

To request a hearing, participants must request one in writing. The participant must include a copy of the Notice of Denial letter from the Money Follows the Person Transition Coordinator. The request should be sent to:

Department of Community Health
Legal Services Section
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

If the participant wishes to keep their services, they must send a written request for a hearing to the Department of Community Health. This request must be received within 30 days from the date of the Notice of Denial letter. If the action is sustained by a hearing decision, the participant may be held responsible for the repayment of continued services that were provided during the appeal.

The Office of State Administrative Hearings will notify the participant of the time, place, and date of the hearing. An Administrative Law Judge will hold the hearing. In the hearing, the participant may speak on their own behalf or they may let a friend or family member speak for them. They may also ask a lawyer for legal help that may be available at no cost through agencies such as the Georgia Legal Services Program, the Georgia Advocacy Office, Atlanta Legal Aid, or the State Ombudsman Office.

CHAPTER 604

TRANSITION PLANS & AUTHORIZATION FOR SERVICES

604.0 Introduction

This section describes procedures for service delivery for MFP participants served through MFP and mechanisms that ensure that participants receive services that meet health, safety and welfare standards. As has been mentioned elsewhere in this manual, MFP services are matched with waiver services, State Plan Services and community services to assist participants resettling to the community. Available waivers currently include CCSP, SOURCE, ICWP, NOW and COMP. In addition to MFP and waiver services, MFP participants transitioning out of nursing facilities or ICFs will receive all State Plan services for which they are eligible and that are appropriate to meet their needs, including mental health services, non-Medicaid federally funded services, State funded programs and local community funded services. This chapter describes the transition planning process that TCs engage in to resettle MFP participants. These processes include participant-directed planning, Individualized Transition Plans (ITP), using authorizations for MFP services and discharge day planning. This Chapter concludes with details on how changes in participant status are to be documented, recommendations for encouraging participant-direction of personal support services (PSS) and standards of promptness.

604.1 Participant-Directed Transition Planning

Participant-directed transition planning focuses on what participants can and want to do in their lives, not on what their deficits are and ‘what needs to be fixed.’ The planning process addresses participant’s needs, preferences and goals. The focus on participant-directed planning helps insure that participants are in charge to the greatest extent possible, in defining the direction of their lives. Once MFP candidates have been identified, recruited and have completed informed consent and health information release (see *Appendix D1 and D2*), MFP Transition Coordinators (TCs) complete the *MFP Transition Screening Form* (see *Appendix G*). This process was described in detail in Chapter 602 of this Manual. Participant-Directed transition planning is the next step.

Participant-directed transition planning is essential for successful resettlement and facilitating person-directed planning is an essential role of MFP TCs. TCs use the *Transition Checklist for Transfer to Community Placement* (see *Appendix J1*) as a guide for the planning process and as a way to identify the steps in the planning process. Not only does the *Checklist for Transfer* identify the steps in the planning process, it contains guidance and recommendations about who should be involved at each step. Each step includes space for the TC to note action steps and results. The *Transition Checklist for Transfer* as a ‘case-management’ tool for tracking the action steps and progress made in the transition planning process.

During participant-directed transition planning, TCs engage the participant in 1) review of medical records, 2) identification and convening the circle-of-friends or circle-of-support, 3) completing a MAP (Making Action Plans), PATH (Planning Alternative Tomorrows with Hope), Life Book, or similar process, and 4) completing the Individualized Transition Plan (ITP).

The TC supports/facilitates participant-directed planning by doing the following:

1. making sure that the participant is not just included in every meeting and decision during the transition process, but assisting her/him to lead the meetings/process to the greatest extent possible.
2. explaining each step of the transition process to the participant. Taking the extra time necessary to assist the participant to prepare for planning meetings, so that s/he can fully participate
3. directing questions and decision-making back to the participant, using questions such as: “what do you think?” This action will support the participant in making her/his own decisions and choices.
4. assisting the participant to clarify her/his goals and choices. If the participant wants to live near public transportation, but also wants to have a lawn and garden, determine which is most important through discussion with the participant
5. encouraging/expecting the participant to do as much of the work as possible involved in planning the move to the community, e.g. calling the utility company and asking about rates
6. supporting the participant in managing the paperwork associated with the transition process. Paperwork will come directly to the participant from agencies and some will require timely responses. Assisting the participant to organize this paperwork and coaching her/him to make timely responses, and
7. holding planning meetings in the community as often as possible. This helps the transition team focus on the primary purpose of planning, being part of the community.

In addition to these planning processes, the TC uses **environmental scans** to identify important characteristics of the **participant** who is transitioning, the community **environments** (type of qualified housing, community locations) that the participant will be using upon discharge, the **tasks** the person will be engaging in, and the **tools** the person will use to complete these tasks. The **PETT (P**erson, **E**nvironment, **T**ask, **T**ools) **Scan** is a useful tool for collecting and organizing information during the person-directed transition planning process. For example, in documenting the planning process, TCs describe strategies that can maintain and increase the independence of the participant. TCs describe the amount of assistance each participant needs, balancing this need with the independent living

skills training the participant receives, the accessibility of the environment and the application of appropriate assistive/adaptive technology. To complete the environmental scan, the TC conducts a review of medical records and facilitates a PATH, MAP, Life Book or similar planning process to collect information about the **participant**. Using the questions in the Individualized Transition Plan (ITP), the TC describes the **environments** into which the participant will be transitioning and identifies the **tasks** the participant needs to be able to complete and the **tools** the participant will use to complete these tasks.

Step 1: Review of Medical Records

It is the TCs responsibility to obtain the participant's signature (or guardian as appropriate) on the *Authorization for Use or Disclosure of Health Information* (see *Appendix DI*). This will allow the TC to review medical records that the nursing facility maintains on the participant, including the *Medication Administration Record (MAR)*, the Minimum Data Set (MDS) Resident Assessment Protocol (RAP) Summary, physician orders, therapy reports, clinical notes and Medicaid eligibility status. During review of medical records, the TC reviews the MAR and the MDS RAP with clinical staff and with the participant to ensure that the information is up to date and reflects the participant's functional needs. Other medical records and assessments will be available on some participants, but MAR and MDS RAP summary are available on all participants.

Step 2: Convening the Circle-of-Friends

The circle-of-friends, also known as circle-of-support, is used to identify who the participant wants to be involved in the person-directed transition planning process. The TC convenes the circle of friends on an informal and semi-regular basis to help the participant accomplish personal goals. To the degree possible, the participant is in charge, both in deciding who to invite to be in the circle, and also in the direction that the circle's energy is employed. The TC acts as the facilitator, taking care of the work required to keep the transition process running. The members of the circle include family, friends and other community members. Family/friends form the inner circle. Unpaid volunteers form the outer circle.

Unpaid volunteers are involved because they care enough about the participant to give their time and energy to helping the participant remove barriers and increase options open to them. For participants with cognitive challenges, the continuity of their circle-of-friends, with the addition of new members over time, is important to maintain focus on the participant's preferences and dreams as then deal with the reality of day-to-day living in the community.

Paid professionals like the TC, the nursing facility discharge planner and the waiver case manger form the outer most circles. Some waiver case managers will be able to be involved in the circle and transition planning process, but not all, due to case management constraints. As a liaison to the waiver case manager, TCs provide as much information them as possible, to facilitate the process of wavier assessment and wavier services planning.

Further Guidance on Working with the Circle-of-Friends

Although each participant's goals are the primary driver for everything the circle does, the relationships that are formed are not just one way. Circle members will all have different knowledge and interests and through synergy, many new opportunities and possibilities previously unknown to the participant, can be considered. An important function of the circle is to regularly re-visit the person-directed plans that are created, to keep the direction current in terms of what the person really wishes to achieve. A circle properly facilitated is empowering to all of the individuals involved.

Step 3: Conducting Participant-Directed Planning

To facilitate the process, the TC uses a MAP, PATH, Life Book, or similar process to assist the participant to visualize their goals and the resources available and needed to achieve them. The TC convenes the transition team to build relationships with the participant, review medical records, explore the participant's strengths and interests, and to develop team unity. Then, in a major planning session that can last from two to four hours, the team develops a comprehensive plan for the participant's future. Through the process, the TC facilitates the definition of the participant's dream, the positive and possible goal that is set for within 6 months to a year. Once the dream and goals are agreed upon, the TC facilitates the action plans that are developed. The participant asks members of the transition team (circle of friends/supports) to enroll or volunteer to be of support. First steps are decided upon, as well as next steps to be accomplished by specific dates in the near future.

Individualized, natural, and creative supports are organized to achieve goals based on the participant's strengths and preferences. Through the facilitation of the TC, the transition team comes together to develop and share a dream for the MFP participant's future, and work together to organize and provide the supports necessary to make that dream a reality. The transition team moves next to documenting the goals, needs, barriers and resources in the *Individualized Transition Plan (ITP)* (see Appendix Q1 and Q2).

604.2 The Individualized Transition Plan (ITP)

The results of participant-directed planning are used to complete the *Individualized Transition Plan* (see Appendix Q1 and Q2). The TC uses this information and the questions in the ITP to collect, organize and document the participant-directed planning process. A completed ITP includes the participant's goals/desired outcomes, choices, preferences, strengths and barriers to transition, including resources/assistance available to achieve the goal/outcome. The TC must complete the ITP prior to all transitions from nursing facility/institutional settings to the community. The ITP:

- Identifies the participant's personal goals and desired outcomes based on 18 specific categories and recommends services to meet these through a combination of MFP services, waiver services, State Plan services and

- community resources
- Identifies risks and creates a plan to manage these risks
- Identifies the emergency back-up plans
- Describes the monitoring process
- Describes the justification or rationale for MFP, waiver and other services and documents the acceptance of these recommendations by the participant's initial
- Documents the transition plan assignments, follow-up plans and required transition team signatures

The TC distributes copies of the ITP showing specific transition assignments to all persons having an assignment to complete. The TC distributes the ITP prior to discharge to assure timely implementation. All members of the transition team can and should receive a copy of the ITP. The Department of Community Health, Office of Long Term Care MFP staff must receive a copy of the completed ITP. The transition team reviews the ITP two to four weeks before the discharge date and makes changes as needed. Updated ITPs are forwarded to all members of the transition team. The following are 18 sections of the ITP that the TC must complete. Included below are discussion questions and issues that should be addressed in the TC's notes.

Q1 MFP Participant Information: Enter the participant's identifying information. Indicate the date the ITP was completed. Include contact information for the TC that prepared the ITP.

Q2 Important Planning Dates: include the projected discharge date.

Q3 Housing Choice/Living Arrangements: Indicate the housing choice priority (1st, 2nd, 3rd choice) and describe the tasks that must be done to secure the choice. Describe:

- the process that will be undertaken to assist the participant with housing information, so that the participant can make an informed choice
- the reasons for the participant's choice
- the anticipated outcome of the choice, i.e. a quieter environment; be closer to friends and family; provide opportunity for greater independence in activities of daily living; is a family setting; or is supported by friends/family.
- the process of considering a roommate; who will investigate
- the transportation options available to be used in the housing search and transportation (private and public) available based on the housing choice selected by the participant
- the role of Peer Community Supporters in the housing search process
- the rationale for improving health, welfare, safety and independence using MFP services, waiver services, State Plan and

community services

Q4 Housing Issues: Using environmental scans, describe the environmental barriers that participants may encounter and what strategies can be used to remove identified barriers. In most cases, the amount of personal supports services (PSS) the participant will need can be reduced by increasing the accessibility of the environment (removing barriers to access), increasing the independent living skills of the participant, and by using appropriate assistive technology. If cognitive challenges are present, describe how the participant will be supported/assisted in activities. As appropriate, provide a description of the following, based on choice of residence:

- Mobility device(s) used
- entering and leaving the residence (ramp or a zero-step entrance)
- climbing/descending interior stairs (railings and grab bars, etc)
- moving around inside the residence (wider doorways, etc)
- using the bathroom (toileting, bathing/shower benches, large-grip grooming tools, roll-in shower, grab bars, ADA toilet, hand-held shower, etc.)
- using the bedroom (lower shelves and clothing racks, Hoyer lift for transfers, etc.)
- using the kitchen (knee space under sinks, lower cabinets, large grip cooking utensils, food prep, eating, etc.)
- using the laundry facilities (washer/dryer)
- control ambient conditions (doors, windows, lights, AC/Heat, telephone, TV, reachers, large-button phones, environmental control systems, etc.)
- using ____ (tool) to _____ (task)
- who will evaluate accessibility
- who will obtain bids for environmental modifications

If the participant is entering an apartment and/or submitting applications for housing assistance, the following are described:

- who will obtain credit reports to review
- who will investigate and how will past unpaid utility bills be paid
- who will obtain a criminal history/background
- what documents will be needed to complete housing applications
- who will obtain utility information and connect utilities
- the rationale for improving health, welfare, safety and independence using MFP services, waiver services, State Plan and community services

Q5 Personal Goals/Desired Outcomes from Transition: Describe the participant's dream as defined in a positive and possible goal, set for within 6 months to a year. Describe each agreed upon goal, action plans developed and transition team members' (circle of friends/supports)

supportive roles. Describe the first steps, as well as successive steps to be accomplished by specific dates. Identify the barriers to resettlement, compensatory strategies and rationale for pre- and post-transition service needs identified by the team. List personal assets/strengths, resources offered by friends and family and community programs and services available to assist the person to remove listed barriers. In addition, describe the independent living skills training the participant needs/will benefit from and when and how the training will be completed. Discuss the purpose of the Quality of Life survey and complete the survey with the participant.

Further Guidance on Working with Participants with Cognitive Limitations/Challenges

Generally, cognitive challenges or limitations involve difficulty with one or more basic functions of the brain: perception (listening, reading), expression (speaking, writing), memory and processing skills. MFP participants with cognitive challenges may have diagnoses including Acquired Brain Injury (ABI), stroke, dementia and/or learning disability (LD). The TC must identify how the participant will perform ADL and IADL tasks in relation to the environment and the tools/compensatory strategies used to accomplish/participant in the following:

- bathing, dressing, personal care, feeding, bowel and bladder program and transfers
- telephone use, shopping, food preparation, housekeeping, laundry, transportation use
- medication management
- money management
- reading, writing, listening, speaking, time management and remembering tasks
- community access
- how will these tasks be managed during the transition period
- how will they be managed post-transition

The presence of cognitive challenges will impact independence. During the completion of the ITP, the TC discusses these tasks with the participant in an effort to **assess needs, identify barriers** and **compensatory strategies** (including assistive technology and assistance). In most cases, the amount of personal supports services (PSS) the participant will need can be reduced by increasing the accessibility of the environment (removing barriers to access), increasing the independent living skills of the participant, and by using appropriate assistive technology. The information that results from this review is captured in the Individualized Transition Plan (ITP).

Q6 Healthcare and Nutrition Goals: It is not uncommon for the

participant to underreport their health problems and medical needs. Describe the process of medical records review with the participant and nursing facility staff. Will the participant need a new primary care provider? Who will be responsible for assisting the participant in locating a PCP and making an appointment with the PCP prior to discharge? Describe the process necessary to obtain a 30 day supply of the participant's currently medications and medical supplies needed on or just before the day of discharge. Describe:

- medical follow-up
- current medications/dosages,
- self-administration of medication and/or assistance needed
- medical supplies needed and source of supplies (bags and tubing, formula, pump, syringes, etc.)
- transfers/lifting/positioning needs (shift positions in bed, pressure relief in wheelchair, etc.)
- current skin care and wound care routines (if the participant has current skin and/or wound care needs. The TC makes an appointment with a wound clinic, prior to discharge)

Nutritional Goals: Describe nutritional goals. The participant may need several weeks of food supply, due to period of time between day of discharge and arrival of social security check. If so, describe how this food will be obtained and who will assist the participant to obtain necessary grocery items. Describe:

- diet; dietary restrictions (food allergies, low cholesterol etc.)
- food intake/preferences and food preparation strategies
- who will assist with food stamps application at DFCS,
- who will assist with food supplies from food banks, vouchers, donated food from circle-of-friends, etc.
- rationale for improving health, welfare, safety and independence using MFP services, waiver services, State Plan and community services

Further Guidance on Healthcare and Nutrition Goals

TCs work with the NF discharge planner and clinical staff to:

- train the participant and volunteer caregivers in transfers/lifting/positioning, skin care and other procedures that will be necessary to meet health and nutrition goals after discharge
- ask NF staff if the participant can manage these process post-discharge or whether home health services should be called in to assist and continue to train the participant at home

Q7 Personal Safety and 24/7 Emergency Backup Plan: Describe:

- risks to the MFP participant's health, welfare and safety based on resettlement choice of residence type
- an individualized contingency plan for emergency back-up for

each identified risk to health and safety in the preferred community living environment

- plans for equipment failures, transportation failures, natural disasters, power outages and interruptions in routine care
- how the 24/7 backup plan will function and be tested and updated; include a description of who will be included in the participant's backup contacts (Primary Care Provider, DME vendor, pharmacy, home health agency, MFP TC, waiver case manager, agency providing personal support services (PSS), backup provided by circle-of-friends, etc.).

Q8 Hearing, Vision and/or Mobility/Dexterity Goals: describe the hearing, vision, personal mobility and dexterity needs and goals of the participant, and the impact of current functioning on activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Describe how the TC, transition team, waiver case manager, other medical specialists (Audiologist, Speech Language Pathologist/therapist, seating and mobility clinic specialist, physical therapist, occupational therapist, etc.) and local vendors will assist in obtaining information, doctor prescriptions and letters of medical necessity needed to obtain DME and assistive devices. Make a connection between the needs of the participant and the request for MFP Pre- and Post-Transition Services.

For Participants with Hearing loss-describe:

- the hearing loss in behavioral terms, how does it affect the participant's performance in ADLs and IADLs, is the loss temporary or permanent, mild, moderate or severe, onset
- the participant's use of residual hearing
- the benefits of amplification, auditory training, or speech reading (lip reading) for maintaining or improving independence
- for severe loss, hearing aid use, how and when the participant is using/not using the hearing aids
- electro-magnetic interference (EMI-high-pitched noises produced by telephones and other electronic household devices) that the participant with a hearing aid is experiencing and the need for hearing aid equipped with telecoil (T-Coil-allows the user to directly couple the hearing aid with compatible telephones and assistive listening devices and to reduce EMI)
- rationale for improved health, welfare, safety and independence through the use of hearing aids and/or other assistive listening devices (ALDs) obtained using MFP services funds, waiver funds, State Plans funds, community funds, etc.
- the process to assist the participant to schedule an appointment with an audiologist for hearing checkup

Further Guidance on Working with Deaf Participants: Deaf

participants may or may not use sign language for communication. If the deaf participant uses sign language, the TC should conduct all meetings with the deaf participant using a qualified sign language interpreter. When the participant doesn't use sign language, the TC will need to cue the deaf participant about the topic of conversation during the ITP meeting. Describe how the deaf participant communicates (if without sign language). The TCs should encourage deaf participants to speak for themselves, even when friends, family and/or nursing facility staff may try to answer for the deaf participant.

For Participants with Visual Disabilities-describe:

- the visual disabilities in behavioral terms, how the vision loss affects ADLs, IADLs, use of corrective lenses/prescription eye glasses and the date they were last seen by a vision care specialist
- if blind, describe the training the participant has received in orientation and mobility, use of a Hoover Cane, and/or a dog guide
- access to print and other media, essential for independence
- how the participant wants to receive information--for participants with low vision, describe the mix of print and other media; for participants with vision, describe use of large print; for blind participants, describe Braille use and media other than print for access to information
- rationale for improved independence and safety through the use of adaptive/assistive devices obtained using MFP service funds, waiver funds, State Plans funds, community funds, etc.
- the process to assist the participant to schedule an appointment with a vision care specialist

Further Guidance on Working with Blind Participants: not all blind and visually impaired people read Braille. Since listening is reading for many people that are blind, describe how/who the participant relies on to read aloud to them. Make connections between the needs of the participant and the request for MFP services.

For Participant with Mobility and/or Dexterity Limitations-describe

- the mobility and/or dexterity limitations in behavioral terms, how the limitations affects ADLs, IADLs
- the needs and goals for equipment and assistive devices for ADLs and IADLs, observe the participant using the equipment and describe whether it appears to work well or whether it appears to need to be improved
- current equipment and the condition, the devices/DME that the participant owns, the age of the equipment and how it was obtained
- rationale for improved health, welfare, independence and safety through the use of DME/adaptive/assistive devices obtained using

MFP service funds, waiver funds, State Plans funds, community funds, etc.

- the process to assist the participant to schedule an appointment with a seating and mobility clinic/specialist

Further guidance on working with Participants with Mobility

Limitations: If the participant's equipment (wheelchair, cushion, cane, crutches, walker, scooter, etc.) appears to be worn out, work with the wavier case manager to determine eligibility for a new device. If the device is not being used, explain the non-use. Did the participant stop using the device because it didn't work well, didn't fit, etc? Ask the participant if there are other devices that s/he has used in the past that would help her/him be more independent. Do not assume that because of severity of disability, the participant will not be able to use a wheelchair or other mobility assistance device. If the participant is vent dependent, ask about the age and function of the equipment. If the participant uses oxygen, ask about the age and function of the equipment. Ask about portable oxygen equipment needed for travel. When was the equipment last checked by a respiratory therapist/technologist?

For wheelchair users, describe process used by the participant to prevent skin breakdown, including the condition of the seating cushions and bed mattress. Describe how the participant transfers (with/without assistance, sit-to-stand, lateral, etc.) and the type of transfer assistance is used/needed (transfer board, a Hoyer lift, etc.). If the participant is experiencing skin breakdown or discomfort, the TC works with the NF clinical staff to refer the participant to a seating and mobility clinic such as Shepherd Center, Emory Center for Rehabilitation Medicine, Warm Springs Rehabilitation Center and/or Children's Healthcare of Atlanta. At the specialty clinic, the participant must be evaluated by a Certified Complex Rehabilitation Specialist, a PT or OT who is also an Assistive Technology Provider (ATP).

Because most nursing facilities do not have wheelchair accessible bathrooms in resident rooms, the TC investigates and describes the use of equipment that will be needed for bathing, bowel and bladder program and personal care.

Q9 Communication Goals: describe:

- the communication needs and goals of the participant in behavioral terms,
- the methods used to communicate (verbal, non-verbal, uses gestures, communication board, Augmentative & Alternative Communication device (AAC), assistive telephone technology, TTY, etc.); any specific signals a person may give to communicate (ex. "whine" means doesn't feel well; "hand to

- the use of any AAC devices used now and in the past
- goals for improved health, welfare, personal communication, independence and safety
- rationale for use of AAC, adaptive/assistive devices obtained using MFP service funds, waiver funds, State Plans funds, community funds, etc.
- scheduled appointment with a Certified Complex Rehabilitation Specialist (CCRS)/Speech/Language Pathologist/Therapist for a communication evaluation for AAC/Assistive Technology

Further Guidance on Working with Participants using AAC Devices:

If the participant has used an AAC device in the past, but currently doesn't have the device, the TC should stop the process of transition planning and medical records review and assist the participant to schedule an appointment with a Certified Complex Rehabilitation Specialist/Speech/Language Therapist, knowledgeable in AAC devices. Once the participant has access to an AAC device (funding is available through Medicaid), transition planning can continue. As with ALDs, AAC devices are examples of auxiliary aids, and services, and are considered reasonable accommodations that are required by the Americans with Disabilities Act (ADA). Describe, as necessary, the process of obtaining and testing lower-cost AAC devices available for short-term trial (loaners) from Georgia Tools for Life/Assistive Technology Resource Centers (ATRCs). If the participant also uses a power wheelchair, describe the process of facilitating the communication between the CCRS/SLP and the seating specialist to ensure that the AAC device is mounted appropriately on the powerchair. Describe the benefits for increasing the participant's independence through the use of environmental control systems. Make a connection between the needs of the participant and the request for MFP Pre- and Post-Transition Services.

Q10 Affective/Social/Recreational Goals: Describe:

- the participant's leisure and recreation interests/preferences and goals and strategies that address the problem of isolation that can lead to re-entry into the nursing facility
- the training the participant will receive to recognize the signs of isolation, the dangers of isolation and strategies to address it
- implementation of an address book (or similar) with contact information for circle-of-friends, emergency back-up, case manager, service vendors, strategies that the participant can use to connect with old friends, lost contacts, etc.
- implementation of a date/date calendar book (or similar) for tracking scheduled events and activities
- how circle-of-friends and Peer Community Supporters are used to assist the participant to engage in social/recreational activities and

- make social/recreational community connections
- community outings planned while still in nursing facility and transportation arrangements
- hobbies or crafts (sewing, quilting, modeling, etc) projects begin while in nursing facility and how these will continue after transition
- type and frequency of recreational/social activities begun while in nursing facility (clubs, church/Sunday school attendance, choir rehearsals, bible study, baseball games, family gatherings, shopping, etc.) with transportation arrangements and how these will be continued after transition
- engaging the participant with volunteer activities
- plans for holidays, holiday traditions
- plans for home-coming party on day of discharge
- rationale for improving health, welfare, safety and independence in social/recreational activities, using MFP services, waiver services, State Plan and community services

Q11 Self Care Goals and Personal Support Services Needed: describe:

- self care routines, goals, the degree of personal independence;
- amount/type of assistance needed for ADLs and IADLs
- the need for Personal Support Services (PSS).
- how Trial Visits-Personal Support Services will be used (as appropriate) to help the participant understand how to use and manage PSS
- rationale for requested MFP services, waiver services, State Plan and community/other services

Further Guidance on Personal Support Services

As TCs describe these needs, they should be aware that the amount of PSS can be reduced by increasing the accessibility of the environment and applying appropriate assistive technology. To understand how much PSS the participant may need, based on the choice of living arrangements, have the participant complete a two-day log of nursing staff assistance in the nursing facility. If the participant is able, ask her/him to note the time and the service provided by nursing facility staff over the consecutive weekdays. Note the time it took to complete each service. This time study will help the participant and the TC get a good general idea of the amount of PSS the participant may need. Use the results of the time study to describe:

- The amount and frequency of assistance in ADLs (eating, toileting, grooming, dressing, bathing, and transfers, etc.)
- The amount and frequency of assistance in IADLs (shopping and food prep, managing finances, household chores, using the phone, participating in community events, etc.)
- assistive technology devices needed for ADLs and IADLs

- who will assist the participant with information needed to make informed choices of assistive technology devices
- amount of time sleeping each day and nightly sleep patterns
- training and supports necessary for the participant to direct PSS

The ITP assessment process as outlined above, will give the TC and participant a good general idea how much personal assistance with ADLs and IADLs the participant may need. TCs recognize that many MFP participants have not used PSS and may need guidance and training in learning how to manage this service. Training for participants should be obtained in collaboration with waiver case managers. Most CILs provide training in these skills.

Q12 Adaptive/Assistive Equipment Use and Needs: Using environmental scans (PETT), describe:

- the participant's anticipated environments, tasks and tools
- the adaptive/assistive devices that the participant is currently using or may need to maintain or improve functioning, include the availability of these devices and whether these devices will need to be obtained, replaced or repaired
- rationale for the purchase of these devices using MFP services funds, waiver funds, State Plan and/or community or other sources of funding
- the process used to assist the participant to investigate the use of AT devices.

Further Guidance on Assistive Devices and Compensatory Strategies for Participants with Cognitive Challenges

To assess the participant's needs in context, plan a shopping trip. Much can be learned about money management by accompanying the participant on a shopping outing to locate and price household items needed for resettlement. To assist with money management, assess whether the participant will benefit from online banking, direct deposit and/or the use of a talking calculator. Assess whether paid support will be necessary. Assess the need for assistance with medication management. Will the participant benefit from a personal medication management system?

Would the participant benefit from a note taker/electronic organizer to receive auditory reminders about appointments, record messages, etc? For participants with time management and prompting needs, consider whether the participant will benefit from timers and/or devices designed to cue or prompt with instructions and aid in time management. For participants who get disoriented, get lost or have difficulty remaining in one place, consider the use of tracking and signaling devices. For assistance with writing, assess whether the participant will benefit from word prediction and word completing software and/or the use of a talking

word processor. Additional information on assistive devices that may assist participants with cognitive challenges and communication, vision, hearing and/or mobility challenges is covered in the sections that follow.

Further Guidance on Assistive Technology for Hearing Loss

Describe the assistive listening devices (ALDs) the participant with residual hearing might benefit from. Would the participant be able to use the telephone if the sound were amplified? Would s/he be able to participate in community events using a wireless amplification system (audioloop, FM, or infrared) to augment standard public address and audio systems by providing signals that can be received by special receivers or hearing aids? Would the participant benefit from devices that provide feedback in alternative ways? For example, would the participant's independence and safety be improved through the use of smoke detectors, doorbells, telephone ring signalers or alarm clocks that link audible feedback to visual signals and/or tactile feedback? Could the participant benefit from captioning for access to information via the TV?

For participants who are deaf or have experienced hearing loss, the importance of access and use of the telephone can't be overstated in improving and maintaining independence and safety in the community. Who will assist the participant to determine if s/he would benefit from the use of a teletypewriter (TTY)? TTYs are used to communicate by text over regular telephone lines. Hearing people like case managers, family and friends and those without TTYs can use Telecommunications Relay Services (TRS) to communicate with the TTY user. TRS allows participants with speech or hearing loss to communicate with family, friends, caregivers and anyone in the world using the telephone. Locally, the Georgia Telecommunications Equipment Distribution Program (GATEDP) provides a variety of specialized telecommunications equipment to qualified applicants who have difficulty using a standard phone. GATEDP staff offers assistance selecting telecommunications equipment and training on how to use it properly. Make a connection between the needs of the participant and the request for MFP Pre- and Post-Transition Services.

Further Guidance on AT for Vision Loss

The participant and nursing facility staff may be unaware of recording and text-to-speech computer applications (also known as screen readers) that use information technology to read digitally produced materials and content. Participants may be unaware that they can receive information on audiotape. Inquire as to the participant's knowledge and preferences.

In addition to access to media, participants may be unaware of other technology that may increase or help them maintain their independence. Variable intensity lamps are used for reading to cut down on glare. View

scanners (known as CCTV), reading machines (that use optical character recognition to convert print to speech), Braille translators (that convert to Braille), and synthetic speech devices may be used to deliver information. The TC must determine if the participant's independence will be maintained or improved through the use of devices with spoken outputs (talking watches, clocks and rulers) or products that use audible cues. Provide a rationale for the purchase of these AT devices using MFP services funding, wavier funds, State Plan funds, community or other funding resources.

Further Guidance on AT for Mobility and Dexterity Limitations

Most disabilities result in more than one limitation. For example, some people with severe cerebral palsy have dexterity, mobility, cognitive and language/communication limitations. Aging often leads to reductions in vision, hearing, mobility and dexterity. TCs recognize that participant's function will vary and will be unique to the individual and will most likely be different from someone else with the same disability. Mobility limitations may affect the participants balance, coordination, sensation, and movement of head, hands, body, legs and/or feet. Participants with mobility limitations have reduced ability or control in turning, bending, or balance; slowness with walking; difficulty in kneeling, sitting down, rising, standing, walking, and /or climbing stairs or ladders. On the other hand, participants with dexterity limitations may have reduced ability to lift, reach or carry objects. Dexterity limitations affect the participant's ability to manipulate objects and/or use arms, hands, or fingers.

Further Guidance on Environmental Control Systems (ECS) are systems that control household appliances, TV, radio, thermostats. ECS can be used to lock/unlock doors, open doors and close doors. Using ECS, participants with mobility and dexterity limitations can control these and other household devices using simple switches (toggles, remote controls, wheelchair joysticks, sip-n-puff switches, voice controlled switches, etc.). Low-cost ECS systems (X-10 modules and controllers) are available from Radio Shack and Lowes. High-tech ECS can be sourced using www.assistivetech.net and www.abledata.com. ECS are important because they can often reduce the amount of personal supports services (PSS) needed by the participant, thus reducing the overall costs to support the participant in the community. Additional sources of funding for ECS include loans for home renovations. As appropriate, TCs provide rationale/justifications for ECS purchase using MFP Equipment and Supplies funding, wavier funding, State Plan, community or other funding resources.

Further Guidance on the use of Personal Computers by Participants

MFP participants may be able to use **personal computers** for many things that will help them maintain or increase their health, welfare, safety and

independence. Participants with dexterity limitations and severe physical disabilities can use many devices to adapt computer to their needs. With computer access and training in computer software, participants have access to environments, to goods and services, to work and to other people. TCs recognize that participants may use computers for augmentative communication, correspondence, calculating, searching, sorting and storing important information, purchasing goods and services, creating music, art and multimedia, to engage in vocational pursuits, and to control environments using ECS. For example, participants might create and manage a household budget, manage their personal supports services (PSS), print checks, pay bills and do their banking online. Workplace trends indicate that most new jobs created today require knowledge and skills in the use of personal computers and productivity software. Participant's vocational pursuits may be enhanced by learning to use computer productivity software, input adjustment utilities and alternative input/output devices. As appropriate, TCs provide rationale/justifications for personal computer and computer access software and adaptive input/output device purchases using MFP Equipment and Supplies funding, waiver funding, State Plan, community or other funding resources.

In addition to MFP and waiver services funding for the purchase of these items, there are additional community resources for obtaining personal computers and adaptive computer software and devices. Contact the Georgia Tools for Life, Assistive Technology Resources Centers (ATRCs) at <http://www.gatfl.org/>. These state-wide agencies maintain a bank of AT equipment for short-term loans to assist participants to 'try out' an assistive/adaptive device for fit and utility. Assessment and training services are also available. For participants with acquired brain injuries and/or spinal cord injuries, contract the Brain and Spinal Injury Trust Fund at www.bsitf.state.ga.us.

Q13 Barriers and Facilitators to Community Participation: describe:

- the participant's community activities prior to entering the NF; with extended family, travel, shopping, spiritual/religious event participation, community event attendance related to crafts/hobbies and interests (sewing/quilting, woodworking, etc.), attendance at arts and cultural events (concerts, theater, art galleries, museums, etc.), outdoor recreational activities (gardening, fishing, hunting, exercise/sports and sports event participation, etc.), social/service/charitable activities (Lions Club, Shriners, voter registration drives, political activities, Meals-on-Wheels, Salvation Army, etc.)
- barriers to re-connecting with these activities
- efforts to assist the participant to re-connect to these activities
- strengths, assets, degree of independence in these activities

- strategies, training and peer support needed to help the participant re-connect with these activities and reduce dependence on personal supports and services (PSS)
- independence in use of money to purchase services; if cognitive challenges are present, describe level of support needed manage personal finances, skills training needed and assistive/adaptive technology devices needed to increase or maintain skills and reduce dependence on PSS
- independence in travel, transportation options, training, adaptive/assistive devices needed to maintain or increase independent travel and reduce dependence on PSS
- rationale for improving health, welfare, safety and independence using MFP services, waiver services, State Plan and community services

Q14 Vocational Goals: describe

- volunteer/vocational/work activities performed prior to entering the NF
- volunteer/vocational/work-related activity goals (as applicable)
- interests, skills, and attitudes related to volunteer/vocational/work goals and future options
- barriers to gainful employment
- personal assets/strengths related to goals
- resources offered by friends and family
- rationale for the use of MFP and waiver services and community programs, including vocational rehabilitation and services to assist the participant to achieve vocational goals

Q15 Transportation Needs: describe:

- transportation goals, needs and barriers
- local/county public and private transportation resources
- barriers to local public and private transportation options
- Process of obtaining (who, what, how, when) transportation vouchers through the GA Aging and Disability Resources Connections (ADRCs), CIL, AAA/Gateways, etc.
- rationale for maintaining and/or improving health, welfare, safety and independence using MFP services, waiver services, State Plan and community/other resources

Further Guidance on Transportation Aids

Non-emergency transportation providers by region include North-Southeastrans, Atlanta-Southeastrans, Central-Southeastrans, East-LogistiCare and Southwest-Southwest GA Regional Development Center. Paratransit services may be available in the participant's current or chosen country of residence. Rural communities with 50,000 residents may have access to DOT 5311 transit providers. Some 5311 transit providers have

vans with wheelchair lifts. Contact the local offices of the County Commissioner for more information. Specially designed transportation aids are available to meet transportation needs. These include van lifts and ramps for wheelchairs and scooters and/or driving controls that can be installed in SUVs, vans, pickups and cars. See Appendix Z: *Transportation Resources* for additional resources.

Q16 Financial Goals: describe:

- financial goals, barriers, assets/strengths, resources to achieving financial goals
- institutional to HCBS/Waiver eligibility status change and SSI transfer including the involvement DFCS Atlanta
- outstanding financial issues, unpaid utility bills
- resources (who, what, when, how, county DFCS office, etc.) for resolving outstanding financial issues
- a budget for community living (see Q22 Income and Resources-Budget for Community Living)
- how rent, utilities, food, transportation, medicines, recreation, etc expenses will be met
- rationale for improving the health, welfare, safety and independence using MFP and waiver services, State Plan services and available community programs and services

Q17 Legal Issues: describe:

- any outstanding or unresolved legal issues, conduct review of criminal history as necessary
- affect on transition, access to housing, transportation and other services and process (who, what, when, how) for resolving outstanding legal issues
- MFP and wavier services and resources available to assist the person to resolve these legal issues, including rationale for each
- Plan for clearing up old, outstanding utility bills

Q18 Family/Guardian Involvement Issues: describe

- Involvement of family members and/or guardian in daily life
- relationships, who is involved
- contact frequency and type of contact (phone calls, visits, etc.), response to interaction with family/guardian
- unresolved family and guardian issues and how these issues will be resolved (i.e. referral to Atlanta Legal Aid Society for assistance to terminate guardianship, etc.)
- rationale for obtaining and using MFP and waiver services and community programs and services available to assist in the resolution of family/guardian issues

Q19 Part A: MFP Pre- and Post-Transition Services: using the table provided, the TC lists the MFP Pre-and Post-Transition Services selected by the participant/team, along with the rationale/justification for each service selected. Describe:

- why the service is needed
- how the service(s) will it be used to increase or maintain the health, welfare, safety and independence of the participant in the community
- costs and whether the costs fall within the maximum allowed for the service
- initials of participant/family for each MFP service selected

Q20 Transition Plan/Assignments: using the table provided, the TC lists the pre-transition, post-discharge and follow-up activity assignments for each member of the transition team and the projected completion date for each assignment. Specific names of team members are included (when possible), assigned to implement the ITP.

Q21 Follow-up Plan: specify the follow-up activities that will be completed, when and by whom

Q22 Income and Resources-Budget for community living: Based on the information obtained about the participant's Income and Resources from the MFP Screening Form and ITP Q16, the TC works with the participant to develop a budget for community living with assistance from the transition team. Include a budget for community living that illustrates:

- how rent, utilities, food, transportation, medicines, recreation, etc expenses will be met
- how PSS personnel budget will be managed (for person who select participant-directed PSS)

Q23 Part B Waiver Services: Using the table provided, the TC lists the waiver services selected by the participant and the waiver case manager. Under "Rationale" the TC describes how the waiver services will work with MFP services to support the participant in the community. The participant initials each waiver service selected.

Q24 Part C Other Services: Using the table provided, the TC lists the State Plan and/or Other Services selected by the participant and the team. Under "Rationale" the TC indicates how State Plan and/or Other Services will work with MFP and waiver services to support the participant in the community. The participant initials each service selected.

Q25 ITP Signature Page: The TC, the participant and each member of the transition team signs the signature page, indicating their agreement to participant in the transition and carry out their assignments.

The TC distributes copies of the ITP showing specific transition assignments to all persons having an assignment to complete. The completed ITP is distributed prior to discharge to assure timely implementation. The MFP participant, circle-of-friends, family members, volunteers and support professional receive a copy of the ITP. The TC faxes a copy of the ITP to The Department of Community Health (DCH), Office of Long Term Care within three days of completion. The team reviews the ITP two to four weeks before the discharge date from the nursing facility/institution, more often if needed and members receive updated from the TC about changes in the ITP. The TC documents updates to the ITP.

Rev. 04/10

604.3 Authorizations for MFP Transition Services

To authorize MFP services, The TC completes the *Authorization for MFP Pre and Post-Transition Services* (see Appendix S). Services included are those that were identified in the ITP meeting and included on Q19. The TC completes all information requested on the form, including participant contact information. The form is electronic and can/should be completed using a computer. If the waiver type (Category of Service) is not known, this should be indicated. Enter the date of discharge. If the date of discharge is not known, enter the anticipated date of discharge. Check the *Initial Authorization* box, if the authorization is the first submitted for the participant's transition services. Check the *Revised Authorization* for any subsequent authorization. Input vendor name and contact information. Using the drop-down menu, select the appropriate pre-transition services in the appropriate column. Indicate the dollar amount authorized for the services in the column for that purpose. Be aware that no authorized dollar amount can exceed the maximum allowed cost per services as specified on the *MFP Transition Services Table* (see Appendix B). Also, note that the total of all pre-transition services cannot exceed \$7844 in the 365 day demonstration period. Total the pre-transition dollar amounts entered and input the total in the "Total Pre-Transition \$'s Authorized" box.

Complete post-transition services authorized in the same manner. No authorized dollar amount can exceed the maximum allowed cost per services as specified on the *MFP Transition Services Table* (see Appendix B). Also, note that the total of all post-transition services cannot exceed \$24,118 in the 365 day demonstration period. Total the post-transition dollar amounts entered and input the total in the "Total Post-Transition \$'s Authorized" box. Enter the TC contact information, save, print and sign the form. Send the completed form via File Transfer Protocol (FTP) to the Fiscal Intermediary for MFP. Send the completed form to the DCH/MFP Office via FTP or by fax. Always complete the most recently revised form.

Once submitted, the Fiscal Intermediary considers the initial authorization to be the official authorization for the participant. TCs include all the MFP service needs that are known at the time. Adequate planning is essential. If additional

service needs are discovered after the ITP has been completed, these additional services must be approved by DCH/MFP Office staff. This process is described later in the manual, see Chapter 606.4, Request for Additional MFP Services.

604.4 Discharge Day Planning and MFP Lock-in Spans

Discharge day planning involves several processes that are coordinated by the TC. The TC: 1) completes the *Discharge Day Checklist* (see *Appendix R*) and faxes to DCH/LTC/MFP office, 2) communicates the termination of institution enrollment in the nursing facility to the DCH Medicaid Program Consultant for changes to the participant's Medicaid eligibility status, 3) if the discharging participant is a Social Security Income recipient, the TC accompanies the participant to the local Social Security office to have the participant's social security check redirected from the institution to the participant, and 4) begins the process of tracking the 365 days of MFP.

Completing the Discharge Day Checklist

Provide the TC's name and phone number in the space provided at the top of the form. Include the date the form was completed. Include the participant's information including the member's name, new address, DOB, phone number, city, state and zip code. Indicate the dispensation of the address change to DFCS, SSA or Other/Both. From the ITP, complete the items requested as indicated by the key (N=Needed; O=Ordered; P=Purchased; N/A=Not Applicable). Provide a short description related to the status of the items (Home, Household items, Food & Nutrition, Health, Rx Medications, Medical Services/DME, Assistive Technology Devices, Social/Recreational, Financial, Transportation, Other). Indicate the waiver the participant is entering and the participant's waiver case manager's phone number. List the MFP and waiver services ordered at discharge. Indicate the service providers' set to being delivery of services. List the name of the pharmacy that the participant will use. Indicate the status of the 24/7 emergency plan. Indicate if new participant needs have been discovered in the discharge planning process and how these new needs will be address.

In the Follow-Up Visits/Quality Management Section, fill in the dates requested for the TCs 1st scheduled visit, the waiver case managers 1st scheduled visit and the LTC Ombudsman's 1st scheduled visit (as appropriate-see *Further Guidance on the Role of Long Term Care Ombudsman Upon Participant Discharge from the Nursing Facility*). Include the County DFCS Office contract, phone and email address. Indicate the status of the Quality of Life Surveys complete with the participant. In the Participant Tracking Section, indicate the LTC/MFP staffer the form who received the fax and the case manager who received the faxed form.

Further Guidance on the Role of Long-Term Care Ombudsman (LTCO) Upon Participant Discharge from the Nursing Facility

LTC Ombudsmen work as members of the transition team for participants in CCSP, ICWP, and SOURCE in three areas: Atlanta, Northwest Georgia, and the Central Savannah

River Area. Participation by Ombudsmen is not mandatory, but rather their involvement should be driven by participant request. If the individual would like to have a LTC Ombudsman present at the team meetings, the LTC Ombudsman should be invited. If the LTC Ombudsman is not able to make the meeting, the meeting can be convened without the Ombudsman or rescheduled at the participant's request, to allow for the participation of the LTC Ombudsman. Ombudsman will make monthly contacts, if requested, to participants who have transitioned into the community into CCSP, SOURCE, or ICWP, unless the participant has moved into a Personal Care Home or Community Living Arrangement. Ombudsman make regularly scheduled visits to PCHs and CLAs statewide and will not provide additional MFP contacts in these settings.

Further Guidance on the Participant's Social Security Check For participants receiving Social Security Disability (SSDI) or Social Security Retirement checks, these checks come to the participant or their designee, and the participant pays the nursing facility for services, retaining \$50 for personal needs allowance. Discharge on the 1st day of the month is the best option for participants receiving SSDI and Social Security Retirement checks, because the participant does not incur charges from the nursing home and can instead use the funds to cover rent, utilities, food and other living expenses.

The process is different for participants receiving Supplemental Security Income (SSI). Checks to these participants have been stopped completely, and the checks are going directly to the nursing facility to pay for facility services, less \$50 for a personal needs allowance. A face-to-face visit with the local Social Security Administration (SSA) office is required to reverse the check from the nursing facility back to the participant. When the participant leaves the nursing facility, s/he must bring discharge paperwork to the meeting with SSA as proof of discharge. The TC accompanies the participant to the SSA office on the day of discharge. The SSA representative completes necessary paperwork to stop the check from going to the nursing facility and redirect it to the participant. In other words, the SSI check will come to the participant and not the nursing facility. This reversal process can take 6 to 8 weeks to occur. Once the participant receives her/his SSI check, it will be retroactive to the discharge date. Participants with SSI must be aware that they will be without funds until this process is completed by SSA. Discharge on the last day of the month or first day of next month is best option for these participants.

Rev. 01/10

604.5 Changes in Participant Status (DFCS Process)

As indicated above, the TC communicates the termination of institution enrollment in the nursing facility to the Department of Community Health Eligibility section for changes to the participant's Medicaid eligibility status. DCH personnel in the state office work with the Department of Family and Children Services Long Term Care staff to close out the participant's nursing facility eligibility span and open up the appropriate waiver span encompassed in

the MFP transition. This is done on the SUCCESS system to include the proper category of eligibility and update the INST screen. Once this change is entered, LTC staff coordinates communication about the transfer to the appropriate county DFCS office.

Eligibility Process for SSI MFP Participants

1. Upon discharge to the community, the TC sends the DMA-59 to the Medicaid Program Consultant at DCH (or arranges for the NH to send it ASAP).
2. TC ensures that the participant is taken to the SSA office on the date of discharge to reinstate their full SSI payments and/or change the address to which payments and correspondence are sent.
3. When the SSA certification letter is received by the participant, TC sends a copy of this letter to the Medicaid Program Consultant.
4. DCH Medicaid Program Consultant updates the participant's eligibility status and closes out NH in the system.
5. Without the certification of SSI eligibility, the participant's Medicaid eligibility status is not changed until an automated update is received from the SSA system.
6. DCH Medicaid Program Consultant notifies DCH Member Services that NH has been closed out, and Member Services creates the MFP lock-in for the participant.

Eligibility Process for Non-SSI MFP Participants

1. Upon discharge to the community, the TC sends the waiver communicator, DMA-6, and DMA-59 to the Medicaid Program Consultant at DCH.
2. DCH Medicaid Program Consultant works with DFCS LTC to update the participant's status and close out NH in the SUCCESS system.
3. DCH Medicaid Program Consultant notifies DCH Member Services that NH has been closed out, and Member Services creates the MFP lock-in for the participant.

Eligibility Process for MFP Participants Transitioning to SOURCE

1. Once SOURCE Case Management has a DMA-6, this should be sent to DCH Member Services through the usual process.
2. In order to minimize delays and ensure services can begin right away for MFP participants, discharge for SOURCE participants should happen on the last day of the month, and it should happen early in the day. Due to the required visit to the SSA, discharges should not take place in months where the last day falls on a weekend or holiday.
3. TC sends the DMA-59 to the Medicaid Program Consultant at DCH as early as possible on the day of discharge. DCH forwards to the Medicaid Eligibility Specialist with DFCS Long Term Care Unit to initiate close-out of NH status.
4. TC must arrange for the participant to be taken to the Social Security Administration on the date of discharge.

5. For those who remained on SSI while in the NH, this step will be to confirm discharge and new living arrangement so that they can begin receiving their full check.
6. For those who lost SSI eligibility while in the NH, this step will be to re-establish eligibility and receive a certification of eligibility letter (letter may be received that day or may be issued by SSA at a later date).
7. Once a certification letter has been received from SSA, the TC sends this letter to the DCH Medicaid Program Consultant ASAP. DCH updates the Medicaid system with member SSI eligibility and communicates with DFCS Medicaid Eligibility Specialist to complete termination of NH Medicaid eligibility.
8. Once DCH and DFCS Long Term Care Unit have closed out NH status, DCH Medicaid Program Consultant communicates with the DCH Member Services Office Manager that the certification letter has been received and the system updated. Member Services goes into the system and dates the SOURCE and MFP lock-in spans retroactive to the date of discharge.

Rev. 07/10

604.6 Encouraging Self-Direction in Waivers

Self-direction is also referred to as “consumer-direction” and “participant-direction.” There are two major features of self-direction—employer authority and budget authority with several choices within these major features. The CCSP, ICWP, NOW and COMP waivers provide participants with opportunities and supports for self-direction. TCs use participant-centered planning to identify preferences and goals for inclusion in the participant’s *Individualized Transition Plan (ITP)* (see *Appendix Q1 and Q2*) including the participant’s desire to direct their Personal Support Services (PSS). Additional services can be self-directed in the NOW and COMP Waivers. The TC explains self-direction options within the appropriate waiver that the participant expects to enter. The TC then makes contact with the appropriate waiver case manager, advising them of the individual’s desire to self-direct her/his personal support services. The TC will coordinate meetings and interviews between the participant, waiver case manager and waiver assessment team as needed.

Once enrolled in a waiver, the participant may select the traditional model of *agency-delivered* services and choose to interview PSS providers and select appropriately qualified provider(s) to meet their needs. On the other hand, if self-direction is chosen, the participant /representative will select a Financial Management Service (FMS) provider and will hire, train, supervise and discharge personal support staff (or other self-directed staff/vendors in the NOW/COMP).

Under CCSP and ICWP, MFP participants must be enrolled in the waiver for a minimum of six (6) months prior to choosing self-direction as an option. Once selected, the case manager will assist the MFP participant and/or representative to develop a budget based on level of care and other assessment tools/criteria. Peer support services are available to provide additional assistance as needed, to

participants and their families or guardians who choose to self-direct. Training and assistance are available to assist the participant to manage the PSS budget, hire, train supervise and discharge PSS staff. These services decrease as the participant's/representative's skill in managing self-direction increase.

For MFP participants who want to self-direct their PSS and who have completed the required 6 month enrollment period, the TC assists the MFP participant to recruit and interview PSS staff . The service plan of the MFP self-directed waiver participant must include an assessment of risk and a back up plan should an issue arise with the self-directed employee. The participant, waiver case manager, and TC work together to develop and monitor the assessment of risk and back up plan to ensure the participant's health and safety. The waiver case manager ensures the service plan meets all requirements for waiver participants who choose self-direction. If the participant experiences a reduction in services or a termination of services, the TC should explain to the participant how to request an appeal to this decision. A TC may also assist the participant in preparing for the Fair Hearing or can assist in making a referral for additional legal assistance.

604.7 Standard of Promptness

The TC completes a number of documents in order to complete each individual transition. These documents must be sent to the DCH LTC MFP Office via fax or secure FTP site according to the following schedule.

Submit by 5:00 p.m. EST within 3 business days of completion:

- MFP Informed Consent
- MFP Authorization for Use of Information
- Transition Screening Form
- Individualized Transition Plan
- Authorization for MFP Services (initial or revised)
- Quote Form for Equipment, Vehicle Adaptation, and Environmental Modifications
- Vendor Request for Payment (if applicable)
- All applicable receipts, invoices, and supporting documentation (vendor quotes, etc.)

Submit by 5:00 p.m. EST on the 15th date of each month:

- MFP Monthly Report of Persons Served (for the previous month)
- Quarterly Report of MFP Program Activities
- Cumulative file of all QOL surveys conducted (for the previous month)
- Update of MFP Housing Choice Voucher (HCV) Participant Tracking Table

Rev. 04/10

Rev. 07/10

CHAPTER 605

HOUSING AND TRANSPORTATION

605.0 Introduction

Locating affordable, accessible, integrated and safe housing is perhaps the most challenging barrier to resettlement. As TCs work with MFP participants to investigate and assess housing options, all housing needs must be discovered, including type of qualified housing, location, accessibility, size, neighborhood, access to services and availability of public/private transportation. It is often the lack of affordable and/or accessible housing that caused the person to enter the nursing facility in the first place. It is important to begin exploring available housing options with the participant as soon as possible, during the MFP Screening process as described in Chapter 602, Section 602.6.

While most MFP participants will qualify for rental assistance or rental subsidy programs, there are often waiting lists for these programs. To avoid delays in moving, the TC begins to identify and research housing options during the MFP screening process. TCs use housing search tools and include the participant's circle-of-friends, peer supporters, the Georgia Housing Search (www.georgiahousingsearch.org), housing specialists at CILs, ADRCs and AAA Gateway offices in the housing search process. The participant's former neighbors and church members may be able to help find housing in the community. Other alternatives include personal care homes (with 4 or fewer unrelated adults), roommate match services and sharing housing with someone who has similar needs.

The following Chapter identifies the TCs role and responsibilities related to assisting the participant to 1) understand and identify qualified housing options, 2) use housing search tools to locate housing, 3) access housing resources, 4) assist with rental assistance and rental subsidy program (voucher) applications, 5) assist the participant to manage the process for home/environmental modifications, 6), assist the participant with making security and utility deposits for establishing a residence and 7) assist the participant to identify and test/try out transportation options.

605.1 Types of Qualified Residences

In the Deficit Reduction Act (DRA) of 2005, Section 6071(b)(6), the term ``qualified residence" means, with respect to an eligible individual--

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and

control; and
(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

Further Guidance on Qualified Residence

The following CMS guidance is intended to help clarify the types of residences in which MFP participants can reside during the MFP Demonstration. Note that the three categories of qualified residences in this guidance:

- Are mutually exclusive;
- Have the same letter headings as in the statute; and
- Contain bullets with clarifying information.

This guidance does not provide an exhaustive list of all types of living situations; rather, it identifies components that must be present in a qualified residence and conversely, components that would disqualify a residence from consideration for MFP. CMS recognizes that separation of housing and services often allows for greater levels of self-direction for MFP participants; however, some persons may prefer services and supports that are an integral component of their home in the community. Therefore, this Qualified Residence Guidance is intended to support a variety of living situations, including supportive housing arrangements. However, all residences should honor personal choice and control of the MFP participants' home and afford opportunities for independence and community integration.

A qualified residence is:

(A) a home owned or leased by the individual or the individual's family member; the lease/deed must be held by the individual or the individual's family member.

- If leased, the lessee must be the MFP participant or a family representative. Leases as defined by Webster's Dictionary are, "Contracts renting property to another for a specified period of time in consideration of rent".
- If an MFP participant would like to share the home they own or lease with other private individuals, including other MFP participant(s), they may either:
 - Sublet or rent their home with a lease granting the other individual(s) exclusive possession to the space being leased or sublet; or
 - Enter into a co-ownership or co-leasing arrangement with the other private individual(s).

In either of these circumstances, all parties must retain independent and equal legal rights to enforcement of the lease and/or ownership responsibilities and, if the other parties are MFP participants, those individuals retain responsibility for meeting the qualified residence requirements.

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.

- The dwelling must have a lease that is considered a legal document by all parties signing or referenced in the lease. The lease may be signed by someone other than the individual or the individual's family representative. The lease must not name anyone other than the MFP participant or a family representative as having domain and control over living, sleeping, bathing, and cooking areas of the dwelling.
- The building must give access to the community. For example, in order to assure security, safety or privacy many apartment complexes have gates, multiple doors, or security guard checkpoints leading to an exit on the street outside of the complex. Each tenant or their family representative must be provided a key, identification card, or keypunch number to easily get in or out of a complex or facility 24 hours a day.
- The apartment in which the MFP participant resides must have lockable entrance or egress to the unit not just the building.
- The apartment in which the MFP participant resides must comport with federal fair housing guidelines.

To be a qualified residence under MFP, leases should **not**:

- Include rules and/or regulations from a service agency *as conditions of tenancy* or include a requirement to receive services from a specific company;
- Require notification of periods of absence, e.g. a person who is absent from a facility for more than 15 consecutive days, or discuss transfer to a nursing facility or hospital;
- Include provisions for being admitted, discharged, or transferred out of or into a facility; or
- Reserve the right to assign apartments and change apartment assignments.

(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

- This residence may be owned and operated by a person or organization other than the individual.
- A residence in which no more than 4 unrelated individuals reside and that is part of a larger congregate care setting (campus) separated from typical community dwellings would not be considered a qualified residence.
- Caregivers, such as personal attendants, are not counted in the four maximum unrelated individuals.

605.2 Housing Search Tools and Strategies

TCs guide participants through the housing search using various tools. To the greatest extent possible, participants work with TCs to do housing searches. See

Appendix A: Documents And Information Needed For Housing Searches for additional information needed to conduct housing searches.

Housing Search Strategies

TCs begin the housing search early in the transition process. TCs engage the circle-of-friends, former neighbors and church members, volunteers and professionals in the housing search. TCs assist participants to ask friends and family members for housing referrals. Friends and family members may know of vacancies before landlords, in some cases.

TCs assist participants to use housing search tools including the **Georgia Housing Search** (Toll Free at 1-877-428-8844 or www.georgiahousingsearch.org) and affordable housing hotlines provided by nonprofit organizations. The Georgia Housing Search is free to TCs and participants and provides a toll-free number for participants who are blind and/or do not have internet access. The website and toll-free number are bilingual. The TC and participant will find available housing information on affordable units, amenities and on accessibility. TCs apply for and receive access to tools behind the public interface. With the cooperation of Pathways, TCs gain access to the Special Needs Housing tools. TCs:

- Contact SocialServe at 1-877-428-8844 and request access to housing units targeting special populations
- SocialServe verifies membership in Pathways (to ensure confidentiality training) via a membership list provided by the Department of Community Affairs (DCA) on a regular basis
- If the TC is not a member of Pathways, the TCs agency is informed that the TC needs to complete the confidentiality training. There is no cost for the TC to complete the confidentiality training available at www.pcni.info
- Once completed, the TC will be added to the Pathways list at www.pcni.info and SocialServe will provide system access logon to the TCs agency.
- The TCs agency is responsible for administration of system access logon for the TC and other agency staff members. DCA monitors the TCs agency for compliance.

TCs assist participants to locate and use housing resource lists from non-profit agencies including the United Way (call 2-1-1 or follow the link to <http://www.unitedwayatlanta.org/docs/211/HousingDirectory.pdf>) and the County Task Forces for the Homeless. TCs and participants make contact with local housing specialists at Centers for Independent Living (CILs), Aging and Disability Resource Connections and at AAA Gateway Networks. The Atlanta Regional Commission maintains a database of resources for older adults, including housing resources, and can be accessed by calling ARC at 404-463-3333 or <http://www.agewiseconnections.com>.

If needed, computers with internet access are located at local branches of county libraries. TCs assist participants to find affordable housing using online resources at:

- <http://www.lowincomeapartmentfinder.com>,
- <http://www.affordablehousingonline.com/apartments.asp?mnuState=GA>
- www.forrent.com, <http://www.housing-assistancenetwork.com/>,
- www.senioroutlook.com for apartments for older adult participants, and
- Apartment finder magazines and local newspaper classified ads online.

Low Income Housing Tax Credit properties (LIHTC) should be researched. Alternatives such as house sharing and roommates should be discussed (www.atlantajcc.org). Certain types of group living arrangements should also be investigated and are covered in more detail later in this chapter.

Often, it will be necessary and beneficial for TCs and participants to drive and/or walk or wheel around various neighborhoods, especially if the participant is looking for a house to rent. Before renting, drive/walk/wheel around the prospective neighborhood or complex in the evening when people are home, to get a better picture of what the neighborhood is like.

Qualified Residence On-site Assessment

Using environmental scans as outlined in Chapter 604, the TC accompanies the participant to review housing on site. An environmental scan is used to evaluate the dwelling. The assessment includes a review of how the participant will:

- get around the neighborhood during the day and after dark, access transportation and services, use sidewalks, lights and crosswalks, etc.
- enter and leave the residence, and presence of ramp or need for a ramp or zero-step entrance
- climb/descend interior stairs and presence of railings and grab bars, etc
- move around inside the residence and presence of/need for wider doorways, hallways, etc
- use the bathroom facilities including toilet, tub/shower, sinks, storage, etc and needed modifications,
- use the bedroom and presence of/need for lower shelves and clothing racks, etc.
- use the kitchen and the presence of/need for knee space under sinks, lower cabinets, access to appliances,
- use the laundry facilities and access to the washer/dryer, etc.
- control ambient conditions (doors, windows, lights, AC/Heat, telephone, TV, etc.
- furniture available/needed
- pet/service animal accommodations
- will the participant live independently or share housing
- will rental assistance be needed, who will investigate
- what needs to be done about utilities deposits, when and by whom
- what needs to be done about security deposits, when and by whom

- what needs to be done about home modifications, when and by whom
- who will handle change of address information
- who will provide keys to care providers

605.3 Subsidized and Other Housing Resources

In addition to housing searches for affordable housing, TCs assist participants to search for subsidized housing. TCs familiarize themselves with three types of subsidized housing: public housing owned by Public Housing Agencies (PHAs), subsidized housing not owned by PHAs and Housing Choice Voucher programs. Properties owned or managed by PHAs, with rent based on 30% of the household's income or approved flat rental rates, are located in senior communities, family communities and mixed income communities. TCs assist participants to apply directly at the community or communities where the participant wishes to live. Participants cannot apply to these properties at the PHA office, but must instead apply at the community or communities of choice. Most of these properties have long waiting lists for units. Generally, the property opens their waiting list once or twice a year. The best strategy is to start the housing search early and remain vigilant in watching for the community's waiting list to open. For a list of Georgia Public Housing Authorities, follow the link to www.hud.gov/offices/pih/pha/contacts/states/ga.cfm

Subsidized Housing not Owned by PHAs

Properties not owned or managed by a local Public Housing Agencies, with rent based on 30% of household's income, should also be considered. Again, the TC assists the participant to apply directly at the property or by contacting the property manager. For a listing of the affordable, subsidized housing properties (not owned by PHAs) in Georgia, follow the link to <http://www.hud.gov/apps/section8/index.cfm> Properties that are subsidized indicate this using the letters BOI (based on income) and/or LIHTC (low-income housing tax credit). These typically indicate that the rental rate of the unit is based on the tenant's monthly income. No pre-approval is needed to apply.

Subsidized Housing and Criminal Background Checks

To qualify for subsidized housing, the MFP participant and members of the participant's household must pass a criminal background screening that has a five-year limitation on convictions for felonious drug and violent criminal activity. If the MFP participant or anyone living in the home has been convicted of a felony relating to drugs or violence in the past five years, the participant is not eligible to receive subsidized housing. TCs should inform participants that a criminal history may impact their ability to obtain subsidized housing, and should assist them to identify other housing options when necessary.

Further Guidance on High Rise Apartments

High rise apartments should be considered in the housing search. Some high rise apartments are owned by PHAs and some are subsidized but not owned by a PHA. The high rise apartment must meet the MFP qualified residence

requirements. The participant's lease cannot include any of the following stipulations:

- That the landlord has the right to assign/change apartments,
- Requiring the tenant to give notice of absences,
- Requiring the tenant to receive services offered in the building as a condition of tenancy. In other words, if the high rise apartment offers a set of services to the residents that they are required to use, this would not meet MFP qualified residence criteria.

Personal Care Homes (PCHs)

Personal Care Homes are options that can be considered, as long as they meet the MFP qualified residence guidelines (four beds or less). Contact the DCH/LTC MFP office for lists of PCHs throughout the state (this listing does not include indications of wheelchair accessibility). The DCH Office of Regulatory Services has regulatory control of these homes. ORS rules and regulations require PCH to have ramps if members living there are wheelchair or mobility device users. Otherwise, PCHs are not required to be wheelchair accessible. ORS indicates that in some areas of the state, the fire department requires PCHs to have ramps regardless of whether the home includes wheelchair user. These fire regulations do not apply state-wide.

Further Guidance on Personal Care Homes and MFP Waiver Slots

As long as MFP participants transition into PCHs with 4 beds or less, they continue to be eligible for MFP transition services (for 365 calendar days after discharge) and there is no reason they would lose their waiver slot. On the other hand, if the participant decides to move to a larger home, the participant would be at risk for losing the waiver slot. In the first 365 days, that waiver slot is tied specifically to MFP. MFP funding created the waiver slot. At the end of the participant's 365 days of MFP, the slot becomes part of the regular waiver and the participant could then move to a PCH with more than 4 beds if they choose.

Rev. 01/10

Further Guidance on Apartment Complex Application Fees

Some apartment complexes charge a fee to complete an application for a rental unit. If the participant has resources to pay these application fees, then the TC should expect the participant to do so. This will help the participant focus on apartment complexes that meet pre-defined criteria (affordability, accessibility, distance from services/family etc) and at the same time help the participant gain experience managing finances/budgeting. If the participant cannot pay these fees out-of-pocket, then these fees can be covered using funds in the Security Deposits service category. If the security deposit needed to secure the unit depletes all the funds available in that service category, then funds from the Transition Support service category may be used to pay application fees. This service is intended to support transition only and expenses will be authorized on a case-by-case basis by MFP Project Director. TCs verify that the MFP participant is being charged the same fee as everyone else who makes application to the complex. MFP

participants with HCVs should not be paying more for application fees than anyone else seeking to rent a unit in the complex.

Further Guidance on Housing Discrimination

TCs should report housing discrimination encountered during the housing search. The Fair Housing Act (Regulations at 24 CFR Part 100) prohibits discrimination based on race, color, religion, national origin, sex, familial status, and disability. The Fair Housing Act prohibits discrimination by any person or entity involved in housing or housing related transactions, including in the terms and conditions offered with respect to housing. This might include:

- Refusal to rent
- Refusal to provide reasonable accommodations
- Refusal to make or allow structural changes needed to enable use of housing
- Overbroad or illegal inquiries into disability, including the requirement that the person with a disability has the “ability to live independently”
- Refusal to allow unrelated persons to live in community (zoning issues)
- Imposition of different terms or conditions of housing
- Failure to construct accessible housing as required by federal laws

Fair Housing Act applies to housing whether private or publicly funded. This applies to a broad range of housing options including traditional apartments, single family homes, units for rent or sale, group homes, congregate living, assisted living facilities and personal care homes. Under the Fair Housing Act, MFP participants are qualified to receive reasonable accommodations, modifications and affirmative minimal accessibility. Examples of reasonable modifications include:

- Widening doorways to make rooms more accessible for persons using wheelchairs
- Installing grab bars in bathrooms
- Lowering kitchen cabinets to a height suitable for persons in wheelchairs
- Adding a ramp to make a primary entrance accessible for person in wheelchair; or altering a walkway to provide access to a public or common use area

Georgia Fair Housing Law requires that persons with disabilities be given reasonable accommodations in regard to rules, policies, practices or services. A tenant or applicant must request that the landlord make the accommodations and may be requested to provide a doctor's statement indicating that the accommodation is necessary. A disability is a physical or mental impairment which substantially limits one or more major life activities. This protected class includes those who have a disability, have a history of having a disability, and those who are regarded as having a disability.

It is prohibited, as discriminatory, for a landlord to refuse to make reasonable accommodations in rules, policies, practices or services when such accommodations may be necessary to afford a person with a disability the equal

opportunity to use and enjoy a dwelling. Examples of reasonable accommodations include a landlord's waiving of a no pet rule for a tenant who needs to use an animal assistant and reserving parking places close to accessible apartments for mobility impaired tenants.

Housing discrimination based on the participant's race, color, national origin, religion, sex, family status, or disability is illegal by federal law. If the participant has been trying to rent a home or apartment and the TC or the participant believe that the participant's rights have been violated, the TCs assist participants to file a fair housing complaint. TCs contact DCH/LTC MFP office to inform office staff of the Fair Housing Act complaint. There are several ways to file a complaint: Follow the link to the HUD site and complete and submit the complaint form online at <http://www.hud.gov/complaints/housediscrim.cfm>, or print out and complete the complaint form, and mail it to:

Office of Fair Housing and Equal Opportunity
Department of Housing and Urban Development
Room 5204
451 Seventh St. SW
Washington, DC 20410-2000

Complaints can be filed with the HUD office in Georgia:
Atlanta Regional Office of FHEO
U.S. Department of Housing and Urban Development
Five Points Plaza
40 Marietta Street, 16th Floor
Atlanta, Georgia 30303-2806
(404) 331-5140
1-800-440-8091
TTY (404) 730-2654

There are also private agencies which help investigate allegations and prepare complaints. Although this agency is located in the Atlanta area, it will provide advice to TCs and participants in other parts of the state:

Metro Fair Housing Services
1083 Austin Avenue, NE
P. O. Box 5467
Atlanta, Georgia 30307
(404) 221-0147
(800) 441-8393

Rev. 07/10

605.4 Section 8 Housing Choice Voucher (HCV) Programs

Several metro Public Housing Authorities (PHAs) and The Department of Community Affairs (DCA) have partnered with DCH/MFP. Under this partnership, PHAs and DCA has set aside Housing Choice Vouchers for MFP

participants. The goal of the initiative is to provide safe, decent and affordable housing to qualified MFP participants transitioning from institutional settings to qualified residences in the community. The MFP/DCA partnership provides limited Section 8 Housing Choice Vouchers that can be used by MFP participants in 149 of 159 counties in Georgia (excluding metro counties). MFP/PHA partnerships provide a limited number of HCVs in several metro areas in Bibb, Chatham, Dekalb, Atlanta , Muscogee, and Richmond counties.

TCs provide assistance and the necessary supports needed for the MFP participant to take advantage of and participate in these Housing Choice Voucher (HCV) programs. Once the ITP has been completed, the TC:

1. completes the *MFP Referral Letter for Housing Choice Voucher Program* (see *Appendix AA*), with the MFP participant. The completed referral letter is legible and is faxed using secure fax to DCH/LTC MFP office, to the attention of MFP Housing Specialist.
2. receives the HCV application packet for the participant,
3. completes the *Application for Section 8 Rental Assistance* with the MFP participant and return the completed application to the appropriate PHA or DCA Regional Office within 15 days. The 15 day period is a HUD (federal) timeline and there are no exceptions.
4. acts as a facilitator during the application process. If the PHA or DCA Regional office has questions regarding the application, they will contact the TC and ask for additional information.
5. receives the participant's determination status letter, (approval or denial for the program). TCs share this information with the MFP participant.
6. upon approval, attends the scheduled voucher briefing meeting with the MFP participant. This briefing meeting provides an overview of the policies and procedures of the HCV program. TCs are required to attend the briefing with the MFP participant. TCs ensure that MFP participants understand the requirements of participation in the HCV program. After the briefing, the voucher will be issued to the MFP participant from the PHA or DCA Regional Office. Once the HCV briefing has been completed, the TC has a direct line of communication established with the PHA or DCA Regional office and can direct all questions or issues that arise to the appropriate PHA or DCA contact person..
7. assists the MFP participant to identify an appropriate community-based housing placement, (apartment, single family home or mobile unit) in which the landlord, property owner is willing to accept the Housing Choice Voucher. After the voucher briefing, the participant is given 120 days to locate suitable housing. This period can be extended on a case-by-case basis. If an extension to the 120 days is needed, the TC can contact the PHA or DCA Regional office representative, provide them with a

status briefing and a letter of request from the MFP participant as asking for the extension.

8. assists the participant to notify the PHA or DCA Regional Office regarding the location of identified housing selection. The TC assists the participant to schedule the housing inspection by PHA or DCA staff.
9. accompanies the participant to the housing inspection and to any scheduled contract signings and housing allocation plan meetings.
10. ensures that the participant's transition services as specified in the Individualized Transition Plan (ITP) are provided and ensure that waiver services are provided to the participant as specified in the Care Plan/Plan for Services.
11. tracks and report requested HCV program utilization data to DCH/LTC MFP and as requested to DCA.

605.5 Home Modifications

TCs assist participants to assess and manage home modifications. MFP provides funding to assist participants to make physical adaptations to their homes or to a family home where they are residing. These services can also be used to make modifications to rental units funded by Housing Choice Vouchers and to community homes on a case-by-case basis. The service can pay for such things as ramps, structural changes such as widening doorways, the purchase and installation of grab-bars and bathroom modifications. These modifications are done to maintain or improve the independence of the participant in ADLs and to ensure health, welfare and safety, and are intended to be for the sole benefit of the MFP participant. Three quotes are required for home modifications. Quotes from contractors must be based on using standard materials. Any materials used beyond basic/standard materials will be subsidized by the property owner.

Using the Quote Form for Environmental Modifications

TCs complete the *Quote Form for Equipment & Supplies, Environmental Modifications and/or Vehicle Adaptations* (see Appendix T). Participant information is completed in the top section of the *Quote Form*. In the table provided, list the three quotes from the three different contractors. Include the quoted amount and check the quote selected. If a quote is selected that is not the lowest quote, provide a justification for the selected quote. The maximum allowed cost for home modifications is \$8,000 in the 365 day demonstration period. Include the property owner's information on the next section of the form followed by the TC's contact information. The TC must sign the form to authorize the home modification. Supporting documentation includes the quotes from contractors and a notarized document giving the homeowner's permission for services, if the owner is not the participant. Send the completed *Quote Form* to the DCH/LTC MFP office via FTP or secure fax. Contact DCH/LTC MFP office for assistance in locating qualified contractors, experienced in doing home

modifications for older adults and people with disabilities (Certified Aging-in-Place Specialists-CAPS).

Further Guidance on Making Modifications to Publicly-Owned Housing

Home modifications to publicly-owned housing can be paid for using MFP funds and waiver program funds for that purpose. According to CMS MFP policy guidance, home modifications within publicly-owned housing is permissible as long as there are no other sources of funding for these modifications, and as long as such modifications are not already the responsibility of the public housing provider. These modifications have to be for the sole benefit of the individual in which the claim for home modifications would be made (for example, this policy should not be construed as allowing payment for public access ramps into the building or other accessibility items for the common areas of the building, for which the public housing provider is already required to make in accordance with the Americans with Disabilities Act (ADA).

605.6 Security and Utility Deposits

Once appropriate housing has been identified, TCs assist participants with securing the qualified residence using MFP funds for application fees and security deposits. The maximum allowed cost for security deposits is \$1,000 in the 365 day demonstration period. In addition to security deposits, MFP funds may be used to assist the participant with utility deposits for their qualified residence. The maximum allowed for utility deposits is \$500 in the 365 day demonstration period. These funds can be used to turn on electricity, gas, water, telephone, cable and Internet service. These funds can be used to pay past due utility bills in order to reconnect services.

Two Payment Options for Paying for Security and Utility Deposits

TCs have two options when arranging for payment of security and utility deposits.

Option 1: TCs can negotiate with landlords and utility providers to accept payment once the participant has discharged from the facility and has moved into their qualified residence. In this case, the TCs request a completed *MFP Vendor Payment Request* form (see Appendix U) from the landlord or utility provider. The vendor completes the MFP Services Rendered For and Payment Instruction sections of the form and the description of the services rendered, including the amount billed. The vendor next submits this form to the TC, who completes the form with the remaining participant information (Medicaid number, DOB). The TC submits the form, along with an invoice/receipt, a copy of the vendor's W-9, and the *Vendor Import File* (see Appendix V) to both the Fiscal Intermediary and the DCH MFP office via secure transfer protocol. Once the information has been verified and approved, the Fiscal Intermediary issues payment directly to the landlord or utility company.

Option 2: When payment is required in advance of discharge, TCs arrange to pay the landlord or utility company using their agency's company credit card or check. Upon discharge, the TC submits the invoice/receipt from the landlord or utility company and the *Vendor Import File* (see Appendix V) to both the Fiscal Intermediary and the DCH MFP office via secure transfer protocol. Once the information has been verified and approved, the Fiscal Intermediary will reimburse the agency for the amount billed.

Further Guidance on Funds for Security and Utility Deposits

Under the guidelines of MFP, the funds for security and utility deposits are intended as one-time expenditures in order to assist the participant with securing and setting up a qualified residence in the community. Proper planning should be done in order to ensure that the residence selected will be safe, accessible, affordable, integrated and will meet the participant's needs. However, it is recognized that there may be occasions when it is necessary for the participant to change residence during the 365 day demonstration period, particularly if health and safety issue are identified. In these instances, it may be possible to use the MFP funds to pay new deposits, if the maximum limit has not yet been reached.

605.7 Transportation Options

Transportation, or the lack of it, should help determine the location of the housing selected by the MFP participant. The importance of access to community services, especially health services, cannot be overstated. Transportation is essential for access to community services. Most urban areas have some form of public transportation; fewer have para-transit systems.

Georgia Department of Community Health (DCH) Medicaid Non-Emergency Transportation (NET) provides transportation for eligible Medicaid members who need access to medical care or services. NET provides services to members when other transportation is not available and eligibility is determined at the time of the contact (see Appendix N: *Non-Emergency Transportation Broker System*).

The TC conducts an inventory of transportation needs as outlined in the ITP Question 15. This includes a review of where the person wants to go on a regular and/or intermittent basis. The type of personal vehicle that is necessary and/or the specialized transportation equipment that may be needed is reviewed. TCs assist participants to make application for local para-transit and other local transportation options (see Appendix Z: *Transportation Resources*).

In rural areas, transportation options are more limited and may only be available through volunteer services. Public transportation options and barriers are investigated and tested, including local/county public and private transportation resources and options. The TC can assist with the process of obtaining vouchers for travel assistance through the GA Aging and Disability Resources Connections (ADRCs), CILs, or AAA/Gateway offices.

Transportation Needs

- Transportation to review potential qualified housing options
- Transportation from the nursing facility on moving day
- Moving services or assistance from circle-of-friends
- Arranging for public/private/para-transit
- Need for and arrangement for vehicle adaptation to personal vehicle
- Travel training, scheduling and testing para-transit and public/private transportation options
- Plan for getting the both regularly scheduled events and recreational trips
- Access to transportation for both short-term and on-going needs
- Applications for private/charity/van services

Using the Quote Form for Vehicle Adaptations

TCs assist participants in obtaining quotes for vehicle adaptations. MFP provides funding to assist participants to pay for vehicle adaptation to a vehicle that is privately owned by the participant or their family. The TC assists the participant to obtain three quotes for the needed adaptations. Vehicle adaptations include the installation of driving controls (when applicable), a lift or ramp for wheelchair or scooter access, wheelchair tie-downs and occupant restraints, special seats or other modifications that are needed to provide for the safe access into and out of and operation of the vehicle. This service does not cover repairs to the vehicle or to the adaptations once they are installed and operational.

TCs complete the *Quote Form for Equipment & Supplies, Environmental Modifications and/or Vehicle Adaptations* (see Appendix T). Participant information is completed in the top section of the *Quote Form*. In the table provided, list the three quotes from the three different vendors. Include the quoted amount and check the quote selected. If a quote is selected that is not the lowest quote, provide a justification for the selected quote. The maximum allowed cost for vehicle adaptations is \$6,240 in the 365 day demonstration period. Include the owner's information on the next section of the form followed by the TCs contact information. The TC must sign the form to authorize the vehicle adaptation. Supporting documentation includes the quotes from vendors and a notarized document giving the vehicle owner's permission for services, if the owner is not the participant. Send the completed *Quote Form* to Acumen via File Transfer Protocol (FTP) and the DCH/LTC MFP office via FTP or secure fax.

CHAPTER 606

POST-DISCHARGE FOLLOW-UP & REPORTING

606.0 Introduction

Post-discharge activities are best accomplished through frequent contact with the participant after discharge. TCs are required to make contact with the participant at least monthly, but it can be important to have more frequent contact with the participant after the move, especially in the first weeks and months. In the nursing facility, there were people around the participant all the time and now the participant may be in an apartment or living with others who are more independent.

It is essential for TCs to be with the participant during the actual transition to ensure that all household equipment and supplies, medical supplies, food, etc. are in the apartment/house. For the first few weeks, the TC should touch base with the participant either in person or by phone, to see how they are doing, if there are any problems, and to let the participant know that the TC is available. The frequency of contact decreases (but never less than one contact each month for the duration of MFP) depending on the level of support the participant needs.

After discharge, the TC is responsible for following the participant's move into the community, providing follow-up during the community transition process, assisting the participant to pursue community integration opportunities and encouraging the participant in self-advocacy activities. There follow-up activities take many forms and may include:

- Making frequent contact with the participant
- Coordinating the 2nd and 3rd admissions of the Quality of Life Survey
- Providing empathy for stress
- Assisting the participant to be aware of and prepare for emotional challenges, let downs and mild depression
- Assisting the participant to look to the future, what does the participant want to do with the rest of her/his life

TCs play important roles in follow-up activities, including working with the Fiscal Intermediary to facilitate payment for services rendered/items purchased, requesting additional services as needed, identifying and monitoring changes in the participant's status, and reviewing the ITP. TCs build collaborative partnerships with participants, family members, friends, peer supporters, local vendors and waiver case managers to ensure that on-going supports and services are in place and functioning as planned, to sustain the participant in the community and achieve a successful outcome.

606.1 Using the Fiscal Intermediary

As has been described elsewhere in this manual, TCs are responsible for assisting participants to identify needed MFP transition services. TCs assist participants to locate and procure these services/products using local vendors. TCs approve invoices from vendors for all MFP services. These processes involve working with the Fiscal Intermediary, Acumen. Using the *MFP Vendor Payment Request* form (Appendix U) and the *MFP Vendor Import File* (see Appendix V), TCs manage and coordinate the procurement of MFP services.

TCs have two options when arranging for payment of invoices from vendors.

Option 1: TCs negotiate with vendors to accept payment once the participant has discharged from the institution/facility and has moved into their qualified residence. In this option, the TCs request a completed *MFP Vendor Payment Request* form (see Appendix U) from the vendor. TC submits the form, along with an invoice/receipt, a copy of the vendor's W-9, along with the *MFP Vendor Import File* (see Appendix V) to both the Fiscal Intermediary (Acumen) and the DCH MFP office via secure transfer protocol. Once the information has been verified and approved, the Fiscal Intermediary issues payment directly to the vendor.

Option 2: When payment is required in advance of discharge, TCs arrange to pay the vendor using their agency's company credit card or check. Upon discharge, the TC submits the invoice/receipt from the vendor along with the *MFP Vendor Import File* (see Appendix V) to both the Fiscal Intermediary and the DCH MFP office via secure transfer protocol. Once the information has been verified and approved, the Fiscal Intermediary reimburses the TCs agency for the amount billed.

The Vendor Payment Request Form

TC completes the bottom section of the form with her/his contact information and provides the vendor with the *MFP Vendor Payment Request* form. The vendor completes the 'MFP Services Rendered For' and 'Payment Instruction' sections of the form and provides a description of the services rendered or products delivered, including the amount billed and date(s) services were rendered/products delivered. The MFP participant signs the form--by signing the form, the participant attests to the fact that the services were rendered or products delivered as described in the form and consistent with what is specified in the participant's ITP. The Vendor submits the form, an invoice/receipt and a copy of the vendor's W-9 to the TC, via fax or mail. The TC receives the *MFP Vendor Payment Request* form and invoice/receipt from the vendor and completes the remaining participant information, the Member's Medicaid Number (MHN#) and Date of Birth (DOB). The TC verifies the information and sends the complete form and supporting documents to Acumen via File Transfer Protocol (FTP) and to DCH/LTC MFP office via FTP or by fax.

The Vendor Import File

TCs complete the information in and Excel spreadsheet as follows:

- **Vendor Tax ID or Federal Employer Identification Number (FEIN) or Social Security Number (SS#)**-from the *Vendor Payment Request* form, 'Payment Instruction' section
- **Vendor Name, Phone, Address, City, State, Zip**-from the contact information for the vendor or agency that rendered the service(s) or delivered the product(s)
- **Member Number (Acumen)**-leave this field blank for Acumen's use
- **Member Name**-the MFP participant First and Last Name
- **Member MHN#**-the MFP participant's Medicaid Health Number
- **Member DOB**-the MFP participant's Date of Birth
- **COS#**-the Category of Service number, the waiver the participant will enter, based on the table of these codes listed on the *Vendor Import File*
- **Acumen 3 Digit Service Code**-the appropriate three digit code for the MFP category of service rendered, based on the table of these codes listed on the *Vendor Import File*
- **Match Enhanced or Regular**-indicate whether the MFP Service is enhanced or regular match (note: the only regular match service is Transportation).
- **DOS**-the date the services was rendered or products were delivered
- **Unit**-leave this field blank for Acumen's use
- **Rate**-leave this field blank for Acumen's use
- **Billed Amount**-enter the amount billed from the *Vendor Payment Request* 'Description of MFP Services' section
- **Reference**-leave this field blank for Acumen's use

Rev. 07/10

The *MFP Vendor Import File* is submitted with appropriate documents (i.e. the *MFP Vendor Payment Request* form, invoice/receipt and vendor's W-9) to the Fiscal Intermediary (FI) and to DCH MFP office via secure transfer protocol. The vendor's W-9 is needed only once per year unless the vendor information changes. The TC submits the *Authorization* either prior to or along with submitting the *Vendor Import File*. Once the information has been verified and approved, the FI reimburses the vendor or the TCs agency for the amount billed, as specified in the FI's payment schedule.

Further Guidance on Reimbursement of Contractor/Agency for Purchases That Cannot Be Refunded in the Event the Participant Doesn't Transition

TCs match each participant's needs to appropriate MFP transition services and community resources as described in the ITP, ensuring effective use of each type of service. TCs ensure that goods and services needed for transition are obtained no earlier than 10 days prior to the discharge date, unless prior approval is obtained from DCH. TCs pay for all goods and services needed prior to transition using contractor/agency funds. TCs do not bill the Fiscal Intermediary (FI) for reimbursement until participant discharge from the nursing facility has occurred.

The contractor/agency is responsible for goods and services purchased for participants, in the event a participant does not transition. If this situation should occur, TCs arrange to return unused items (such as furniture or household goods) for a refund. The contractor/agency may also elect to hold and store new and unused items for re-use.

606.2 Requests for Additional MFP Services

TCs make every effort to identify the participant's needs to the greatest extent possible during person-directed planning and during the completion of the ITP. TCs then authorize appropriate MFP services based on these needs. When the need arises for additional MFP services that were not initially authorized or when the participant needs more of a service than was initially authorized, the TC can complete and submit the *Request for Additional MFP Transition Services* (see Appendix X). This *Request for Additional MFP Transition Services* must be approved by the DCH/MFP Office. Once approved, the TC submits completed reimbursement documentation, the *Authorization for Transition Services*, *Vendor Import file* and receipt/invoice, to the Fiscal Intermediary via FTP and to DCH/MFP office via FTP or fax. The Fiscal Intermediary considers every subsequent authorization a revision to the original authorization, even when the subsequent authorization is for a different service, or an entirely new category. As needed, TCs may submit multiple authorizations for a participant.

The Request for Additional MFP Transition Service

Use this form to obtain approval for MFP transition services not initially identified in the ITP. Services listed must be needed by the participant and not initially identified in the ITP. The TC completes the participant information in the top section of the form. In the table provided, the TC indicates the additional transition services needed and the rationale or justification for each service. The MFP participant must initial each additional service. The TC sends the *Request for Additional MFP Services* to the DCH/MFP office for approval. Once approval is obtained, the TC submits the *Request* along with the reimbursement documentation (the *Authorization for Pre-and Post-Transition Services*, *Vendor Import File*, etc. to the Fiscal Intermediary via FTP and to DCH/MFP office via FTP or fax.

Further Guidance on the Requests for Additional MFP Services

The following scenario is presented to help clarify the use of the *Authorization MFP Transition Services* (see Appendix S) and the *Request for Additional MFP Transition Services* (see Appendix X). The TC facilitates Joe Participant's ITP meeting and the team determines that he needs furniture, household goods, and a wheelchair ramp, as he is moving back home to live with relatives. These items are included in the ITP Question 19, along with the rationale for them. The TC then submits an authorization form to Acumen and DCH authorizing the estimated amounts for each of these categories. At this point, furniture and household goods can be purchased close to the discharge date, and quotes can be

obtained for building the ramp (the *Quote Form for Environmental Modification* will also be sent to DCH and Acumen once quotes are obtained). After discharge, the TC bills Acumen using the *Vendor Import File* for the authorized items and includes appropriate documentation (receipts for furniture and household goods, invoice/receipt and *Vendor Payment Request* from the vendor selected to build the ramp). Acumen pays the ramp builder accordingly. Several months later, Joe Participant falls during a transfer to his shower bench in the shower and injures himself. After talking with Joe and his relatives, the TC determines that he needs to have grab bars installed in his shower to make it safer. The TC completes the *Request for Additional MFP Transition Services* (see Appendix X) and submits to DCH to provide rationale for the expense. Another authorization form is completed authorizing additional funds in home modification for the grab bars (assuming funds remain), and the “revision” box is checked on the *Authorization for MFP Transition Services* and sent to Acumen and DCH.

606.3 MFP Participant Status Changes

TCs are required to report **ALL** changes in participant status, including (1) when MFP participation ends, (2) when the participant enters the hospital or nursing facility (i.e. was re-institutionalized), (3) when re-enrollment begins, and/or (4) when the participant moves or her/his address changes. TCs are responsible for reporting these status changes using the form, *MFP Participant Enrollment Status Change Form* (see Appendix Y).

TCs are vigilant in this responsibility. TCs know that if the participant is re-institutionalized for 30 days or more, the participant is discharged from MFP in accordance with CMS guidelines. The participant is then considered to be an institutional resident. A participant may reenter the demonstration without meeting another 6 months institutional residency requirement, if the institutional stay is less than six (6) months, but the participant would need to be re-evaluated for discharge to the community to determine if any changes in the ITP and the service plan are warranted to prevent a re-admission to an institution. The waiver case manager conducts a re-assessment per waiver policy, for institutional stays of longer than six months. Institutional residency requirements apply and the participant will be re-evaluated like a “new” MFP participant.

Using the MFP Participant Enrollment Status Change Form

Complete the top of the form with the participant information. ‘MHN’ is the participant’s Medicaid Health Number. ‘Date of Discharge from the NF/Institution’ is the initial date the participant discharged from the nursing facility or institution, the date that the participant’s 365 days of MFP began. ‘Waiver’ is the Category of Service for the waiver into which the participant discharged.

In the next section, enter the Date of Status Change, the actual date of the status change, not the date the form was completed. Enter the Type of Status Change,

check only one box. If the participant moved, enter the new address, city and zip code. If enrollment ended, check the most appropriate box (1 through 7). If the participant was re-institutionalized, check the most appropriate box (1 through 8). If the participant re-enrolled or moved, check the type of qualified residence used after the move and indicate if the participant moved in with family members. In the last section, complete the contact information for the TC. Send the completed form to the Fiscal Intermediary (Acumen) via FTP and to DCH/MFP office via FTP or by fax.

606.4 Review of the Individualized Transition Plan/Person-Centered Development

After resettlement in the community, TCs review the Individualized Transition Plan/Person-Centered Development with each participant, to identify if the participant is accessing planned supports and services. TCs and participants determine if additional supports and/or services are needed. TCs assist participants to plan and take the steps necessary to obtain additional supports and/or services. Together, TCs and participants review the following areas:

- **Housing**
 - Appropriate to the participant's needs
 - Have modifications been completed and are the working properly
 - Are additional modifications needed to assist the participant to live more independently
 - Are additional assistive technology devices needed for independence in ADLs/IADLs
 - Is the rent being paid, or have rental assistance or subsidies been obtained, are the payment working as expected
 - If there is a roommate, how is this working out
 - Are additional household furnishings or household good and supplies needed

- **Personal Goals/Desired Outcomes**
 - Has the 6 month goal been realized
 - What is the next 6 month to a year goal, action plans, tasks, responsibilities
 - What barriers to community participation need to be addressed
 - Has the independent living skills training been completed, what other training is needed
 - Has the Quality of Life survey been schedule/completed
 - What has been achieved as a result of peer support, what else needs to be achieved
 - Are there supports and services that the participant needs but is not receiving at this time
 - What should the TC and wavier CM do and what should the participant do to address these needs (opportunity to develop self-advocacy skills)

- **Healthcare, Health and Nutrition**
 - Are medications/dosages current, are they self-administrated, what assistance is needed, have these issues been worked out
 - Does the participant have a pharmacy and are current prescriptions set up for refill at the designated pharmacy, with appropriate Medicaid and Medicare/private insurance information
 - Has the Primary Care Physician been established, have follow-up appointments with the PCP and specialists been completed
 - Have DME and assistive technology devices been procured and are they working, have users and support staff been trained in their use (shower transfer bench/chair, wheelchairs, commodes, beds, Hoyer lifts, etc.)
 - Are special diet/restrictions in place and is the participant getting adequate nutrition
 - Are there supports and services that are needed, but not being receiving at this time
 - What should the TC and wavier CM do and what should the participant do to address these needs (opportunity to develop self-advocacy skills)

- **Mental Health Supports**
 - Are there mental health needs and/or substance abuse needs that should be addressed
 - Does the participant acknowledge these needs and does she/he want assistance
 - How would the participant prefer to have these needs addressed
 - Are these needs being addressed

- **24/7 Emergency Backup Plan**
 - Have risks to health, welfare and safety been identified
 - Has the individualized contingency plan for emergency back-up for each identified risk been put in place and is it operating effectively
 - Are plans for equipment failures, transportation failures, natural disasters, power outages and interruptions in routine care in place and have they been tested
 - Has the participant made contact with all persons who are included in the participant's backup contacts (Primary Care Provider, DME vendor, pharmacy, home health agency, MFP TC, waiver case manager, agency providing personal support services (PSS), backup provided by circle-of-friends, etc.)

- **Self Care and Personal Support Services (PSS)**
 - If the participant has PSS, how is it working, are the hours of assistance sufficient

- Can the participant provide adequate direction to her/his PSS staff
 - Does the participant need additional information on how to effectively manage PSS
 - What progress has been made in achieving independence in ADLs and IADLs
 - What independent living skills has the person attained and what additional training is needed, from whom and how will this IL skills training be obtained
 - What should the TC and wavier CM do and what should the participant do to address these needs (opportunity to develop self-advocacy skills)
- **Affective/Social/Recreation/Community Participation**
 - What social and recreational activities or hobbies are being engaged in, are there other social/recreational activities that are of interest, is the participation routine and integrated
 - What supports and/or assistive devices are needed for participation in social, faith and recreational activities, are there other assistive devices that would facilitate communication/social/recreational and community event participation
 - If the participant has so chosen, is she/he involved in a religion of choice, has she/he been supported in reintegrating into religious services of choice
 - Have celebrations been planned for the participant's birthday, holidays and/or special occasions (i.e. 1st anniversary of move out date)
 - What should the TC and wavier CM do and what should the participant do to address these needs (opportunity to develop self-advocacy skills)
- **Vocational/Employment**
 - Does the participant want to volunteer or work, is the participant volunteering or working in an integrated community setting
 - Does the participant want to be employed, full-time or part-time
 - Does the individual have a job, if not, what efforts are being undertaken to find employment, including to vocational rehabilitation services, job clubs, one-stop career centers, etc.
 - Are other supports needed to assist in the job search and/or employment setting, including assistive devices for computer access and communication, adapted workstations, ergonomic tools, training (pre-employment, job search, etc.)
 - What should the TC and wavier CM do and what should the participant do to address these needs (opportunity to develop self-advocacy skills)
- **Transportation**

- Is accessible public and/or private transportation available locally
 - Is use being made of available options, including para-transit and non-emergency medical transportation (NET), has certification for para-transit and NET been completed
 - Is training needed on how to use available options, has a travel trainer been identified
 - Have travel vouchers been investigated/obtained
 - Have vehicle adaptations been completed
 - Is there additional needs that have been identified
 - If transportation is needed for employment, has vocational rehabilitation been contacted for assistance/additional resources
 - What should the TC and wavier CM do and what should the participant do to address these needs (opportunity to develop self-advocacy skills)
- **Financial Issues**
 - Has a budget been developed and are all expenses being tracked, are discussions and problem solving occurring on a regular basis to ensure that financial issues are adequately addressed
 - Has the budget for PSS being carefully watched and managed
 - If the participant is self-directing PSS, how is this working, is there a need for additional assistance and/or training to perform these tasks
 - What should the TC and wavier CM do and what should the participant do to address these needs (opportunity to develop self-advocacy skills)
- **Legal Issues**
 - Have any legal issues been resolved, if not what needs to be done to resolve these
 - Is assistance needed to resolve them form legal aid
 - What should the TC and wavier CM do and what should the participant do to address these needs (opportunity to develop self-advocacy skills)
- **Family/Friends/Guardian Issues**
 - Have family and/or friends been involved in the transition
 - What strategies that encourage the involvement of family/friends
 - Are family/friends being updated on resettlement, when and by whom

606.5 Reporting Requirements

TCs submit the following documentation ASAP:
Participant Transition Documentation

TCs submit completed copies of the following documents and others as required by the MFP Office, for each MFP participant:

- *Authorization for Use or Disclosure of Health Information* (see Appendix D1)
- *MFP Consent for Participation* (see Appendix D2)
- *MFP Transition Screening Form* (see Appendix G)
- *Individualized Transition Plan (ITP)* (see Appendix Q1)
- *Authorization for MFP Services* (see Appendix S)
- *Quote Form for Equipment & Supplies, Environmental Mods, and Vehicle Adaptations* (See Appendix T)
- *Vendor Request For Payment To TC* (see Appendix U)
- *Referral for Housing Choice Voucher* (see Appendix AA)
- *MFP Vendor Import File* (see Appendix V)
- *Discharge Day Checklist* (see Appendix R)
- *MFP Sentinel Event Report* (see Appendix AB)
- *Participant Enrollment Status Change* (see Appendix Y)

TCs submit the following reports to the DCH MFP Office via secure FTP transmission by 5:00 p.m. EST on the 15th of each month for activities in the preceding month:

1. Monthly Report of Persons Served
2. Quarterly Report of Program Activities
3. Excel spreadsheet of QOL surveys completed
4. Update of MFP Housing Choice Voucher (HCV) Participant Tracking Table

Rev. 04/10

Monthly Report of Persons Served

Using an Excel Spreadsheet, the TC is required to submit the following information on each MFP participant. Each record in the spreadsheet must begin with the following fields: participant last name, first name, date of birth and Medicaid number (12 digits). This information identifies the participant's information that follows in the record. In addition, each participant record must contain the following fields/information:

- **Target Population**-indicate the participant's population, based on the following; OA=Older Adult, PD=Physical Disability, ABI=Traumatic Brain Injury/ABI=Acquired Brain Injury, DD=Developmentally Disabled
- **Facility/Institution**-the name of the nursing facility/ICF-MR where the participant is currently residing
- **Date Screening Completed**-date the MFP screening form (see Appendix G) was completed and submitted to DCH/LTC/MFP office
- **Date ITP completed**-date the Individualized Transition Plan (ITP) (see Appendix Q1) was complete and signed by all members of the transition team and submitted to DCH/LTC/MFP office

- **Waiver Referral Date**-date the participant's waiver application was submitted
- **Waiver Approval Date**-date participant is accepted by the waiver, (the waiver service start date), include the name of the waiver
- **Date QOL Completed**-date the participant completed the initial Quality of Life Survey (see Chapter 602.8 for details)
- **Facility D/C Date**-date of discharge from the nursing facility/institution
- **Pre-Transition Services Authorized**-total amount authorized for all pre-transition services
- **Pre-Transition Expenses**-total amount spent for all authorized pre-transition services
- **Post-Transition Services Authorized**-total amount authorized for all post-transition services
- **Post Transition Expenses**-total amount spent for all authorized post-transition services
- **Self/Participant Direction Options**-indicate the participant's options to direct services
- **Self/Participant Direction Choice**-indicate the participant's choice regarding options to direct services
- **State Plan Services Recommended/Received**-indicate other Non-Medicaid Services that the participant has made application for or is receiving, including; Food Stamps, Adult Protective Services, Care giver Supports, Older Americans Act Services, Social Services Block Grant Services, State Funded Services, services obtained from community agencies and community-based organizations (ADRCs, CILs, AAA, ATRC, etc.)
- **Participant Status**-indicate if participant is deceased, ineligible for MFP, refused MFP, etc.
- **Date of Reinstitutionalization**-date the participant re-entered a nursing facility or institutional setting
- **Reason for Reinstitutionalization**-indicate the reason for the participant returned to the nursing facility or other institution (see Chapter 606.3 for more details and Appendix Y for corresponding form)
- **Date of 30 day Follow-up**-date of 30 day face-to-face visit with the participant in the community post-discharge
- **TC signs and dates the form as verification of accuracy**

Rev. 04/10

Quarterly Report of Program Activities

TCs answer questions about transitions by population, occurring in the quarter covered by the report. Qualitative comments should be included on requested questions. TCs answer questions on recruitment and enrollment of MFP participants, informed consent and guardianship, outreach, marketing and education. TCs answer questions regarding how they involved community agencies and community based organizations in coordinating transitions, describing efforts to leverage available community resources. TCs respond to questions about HCBS waiver services and participant access to services. They

answer questions regarding participant-direction. Finally, TCs complete questions regarding quality assurance and quality improvement. Qualitative comments are necessary to complete the report.

Monthly Report: Excel Spreadsheet of QoL Surveys Completed

MFP Quality of Life File must be submitted as an Excel file to the MFP Office via secure FTP transmission. The survey software provided by MPR will produce the file in the proper format.

Monthly Report: Update of MFP HCV Participant Tracking Table

TCs submit a MFP HCV Participant Tracking Table with the following information on each HCV participant:

- Participant Last Name, First Name
- Participant SSN (last 4 digits)
- Responsible TC
- Preferred County of Residence
- Date *MFP Referral Letter for DCA Housing Choice Voucher Program* (see Appendix AA) faxed to DCH MFP office
- Date Completed HCV application sent to DCA Regional Office
- Date of HVC Voucher Briefing
- Date of HQS Inspection
- Date of Passed Inspection/HAP Contract Begins

606.6 Continuity of Care (Day 366 and beyond)

TCs collaborate with waiver case managers (CMs) to ensure a smooth transition to waiver services. TCs are expected to attend training with CMs when possible and assist CMs with information and feedback about wavier services needed to refine the service plan and assist the CM to establish risk management systems, including 24/7 emergency backup systems. TCs are responsible for informing the participant 30 days before their MFP services are set to end and ensuring that the participant is aware that their waiver, state-plan and other community services will continue, unless the services are no longer needed or the participant does not meet level of care. Thirty days prior to the end of their MFP services, TCs send each participant a *MFP Enrollment End Letter* (see Appendix AD).

606.7 Professional Development Requirements

Training of TCs is critical. TCs are required to attend scheduled trainings with the Home Community Based (HCB) waiver case managers, DHR Division of Aging Services (DAS) and DHR Division of Mental Health, Developmental Disability and Addictive Diseases (DMHDDAD), Area Agencies on Aging (AAA), Aging and Disability Resource Connections (ADRCs), and the Georgia Independent Living Network (GILN).

TCs are required to develop specialized knowledge in waiver services/options, transition, participant-direction, following service budgets, procurement of specialized medical equipment and assistive technology devices, arranging for peer supports, locating housing and transportation and obtaining other community resources. TCs are required to engage in professional development as directed and coordinated by the DCH Office of Long Term Care, MFP staff.

Core training includes (but is not limited to) the following:

- MFP Benchmarks and Scope
- MFP one-time transition services,
- participant rights and responsibilities,
- informed consent,
- screening and matching needs to MFP services
- person-directed planning and the individualized transition plan,
- resources for resettlement (i.e. SSI/ SSD),
- enrollment in HCBS waivers,
- HCBS services
- self/participant-direction,
- Medicaid eligibility and the role of DFCS
- Conducting the Quality of Life Survey
- housing and rental subsidy programs, and
- accessing local transportation options
- reporting requirements, policies and procedures

Related and Specialized training includes (but is not limited to) the following:

- introduction to disability and working with older adults
- working with peer support networks
- working with guardians and the limits of guardianship
- DME and assistive/adaptive technology and services
- Non-Medicaid and community resources
- civil rights under Olmstead v. LC, and Americans with Disabilities Act
- HCBS eligibility, assessments and working with clinicians,
- home and community-based waiver options,
- independent living,
- community and regional resources,
- other issues as deemed necessary for achieving MFP benchmarks/project outcomes

CHAPTER 700

SCOPE OF MFP TRANSITION SERVICES

701 General

This section is designed to be a quick reference guide to MFP Transition Services. Each sub-chapter beginning with 704 lists an MFP Transition Services. The service is named, followed by a short description. This is followed by a more thorough description of how TCs should utilize the service. Rate information for each service is included. Each subchapter concludes with exclusions and special conditions related to the specific service.

702 Exclusions and Special Conditions

Subchapters beginning with 704 conclude with exclusions and special conditions related to the specific service. See headings in bold titled, “Further Guidance...” for exclusions and special conditions that apply.

703 Duplication of Services

MFP funds are not used to pay for equipment and supplies that are otherwise covered through Medicaid Durable Medical Equipment coverage or through Medicare coverage. TCs assist participants in working with their physicians, nursing home discharge planners, or waiver case managers to get prescriptions and place orders for such covered equipment and supplies.

There are three MFP services that provide supports to participants that are the same as or similar to services included within the ICWP, NOW, and COMP waivers: Environmental Modification, Equipment and Supplies, and Vehicle Adaptations. In the event that MFP funding is available to cover these items, TCs can authorize the use of MFP services before the participant accesses the waiver service. By accessing MFP services before the waiver, participants may be able to preserve or prolong waiver benefits that have an annual or lifetime maximum that may be needed after the 365 day demonstration period has ended.

704 Peer Community Support

Description: This service provides the assistance of a peer supporter to MFP participants, if they choose. Peer supporters assist participants with networking and building connections to individuals and associations in their community.

How It Works: Peer supporters are typically individuals who have a disability (that may or may not be similar to that of the participant) and may have resided in a nursing facility and have familiarity with the barriers faced during transition. Peer supporters can be certified through the Georgia Peer Support Network (<http://www.disabilitylink.org/docs/psp/peersupport.html>) or may be unaffiliated.

Rate: This service provides for a maximum of 40 hours at \$30 or for a total of \$1200 throughout the 365 day demonstration period.

Further Guidance on Peer Community Support

If the Peer Supporter is available and the participant is interested in the service, it is recommended that the TC authorize the entire amount for the service in order to allow the participant to get the maximum benefit from working with a Peer Supporter. Early and frequent contact with the Peer Supporter can be the relationship ‘glue’ that will assist the participant to connect to or re-connect to and establish themselves in the community. In many cases, the Peer Supporter will become friends with the participant, and this friendship will help to sustain the participant during discharge, throughout the 365 days of MFP, and will most likely continue post-MFP.

Rev. 01/10

705 Trial Visits-Personal Support Services

Description: Participants considering moving into their own home or apartment, or that of a family member, may wish to try Personal Support Services (PSS) on a trial basis. The purpose of this service is to give the participant an opportunity to manage and direct PSS staff before they resettle. Participants who wish to move into a Personal Care Home (PCH) may wish to spend time with the PCH staff. This service may also be used to provide for temporary PSS for participants who have transitioned, but whose PSS services do not begin in the first 24 hours after discharge. In some cases, the nursing facility will arrange for assistance during this period of time (discharge until the beginning of waiver PSS). In some cases, arrangements can be made with family and friends for natural supports during this period. When other arrangements cannot be made, the participant can use Trial Visits-PSS until waiver services begin. The purpose of the service is to provide PSS to assist the participant post-discharge, until waiver PSS begins. This service may be particularly helpful for participants who have limited natural supports from family and friends.

How It Works: This trial visit will allow the participant to manage and direct PSS or PCH services for assistance with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs). Participants will have the opportunity to manage and direct the work of PSS/PCH staff on a trial basis so that both the participant and the PSS/PCH staff know what to expect after discharge. This service only applies to PSS or Personal Care Homes (cannot be used for skilled nursing visits), and is generally used prior to discharge from the facility. On a case-by-case basis, it can be used to provide PSS to assist a participant immediately after discharge.

PSS Rate: This service provides for PSS visits paid at the current rate funded through the waiver the participant will be entering. For example, participants entering the ICWP waiver can receive trial PSS visits with enrolled ICWP providers at a rate per hour that matches the rate paid in that waiver. The maximum number of trial PSS hours available will vary by waiver, but cannot exceed \$1044 per member. Based on reimbursement rates published on July 1,

2009, ICWP participants can receive a maximum of 74 hours and CCSP and SOURCE participants can receive a maximum of 55 hours. PSS hours are not to be provided as continuous 24-hour care, but rather in blocks of time consistent with what the participant will be receiving once living in the community. If this service is used post-discharge, it should be integrated with natural supports when and where available.

PCH Rate: This service pays for 1 unit of residential services to be provided through an enrolled waiver Personal Care Home at the rate of \$65 per day and limited to 5 days.

Further Guidance on Trial Personal Support Services

If a PSS provider has already been identified to provide services through a waiver upon discharge, the participant may wish to use this service to have a trial visit with that provider. However, the hours provided through this service do not affect the number of hours that will be provided through the waiver once the participant has discharged.

706 Household Furnishings

Description: This service provides assistance to participants who need basic household furnishings to help them transition back to the community.

How It Works: During planning, the TC assists the participant in identifying any furnishings that they already own (still in their home, in storage, etc.), as well as furnishings available from family, friends, and other sources. Remaining furniture needs are detailed with the participant and included in the ITP along with a plan for locating and pricing the needed items. Household furnishings are items such as: table, chairs, bed, desk, dressers, or large appliances (such as a washer and dryer) that are needed in a house or apartment and necessary to allow the participant to set up a home.

Rate: This service provides a maximum of \$1,500 to be used during the 365 day demonstration period.

Further Guidance on Household Furnishings

This service does not provide for items such as televisions, stereos, DVD players, or purely decorative items (such as vases, wall art, etc.). These furnishings are intended to meet the needs of the participant, and are not to be used to refurnish the home of a relative. While this service is intended as a one-time start up service to help the participant establish a home, it is recognized that these funds may need to be used throughout the year in certain circumstances.

707 Household Goods and Supplies

Description: This service provides assistance to participants who need basic household goods to help them set up their qualified residence.

How It Works: During planning, the TC assists the participant in identifying any household goods and supplies that they already own, as well as items available

from family, friends, and other sources. Remaining needs for household goods are detailed with the participant and included in the ITP along with a plan for locating and pricing the needed items. Household goods and supplies are items such as bedding, towels, washcloths, cooking items, cleaning supplies, plates and silverware, etc. See Appendix P: *Startup Household Goods and Supplies* for a list of recommended household startup items. This table can be used to assist the participant to identify what they already have and what is needed. The TC coaches the participant to shop wisely. This service can also be used to provide a one-time purchase of groceries for setting up the participant's qualified residence. Alcohol and tobacco products can not be purchased with these funds. This service does not provide for items such as televisions, stereos, DVD players, or purely decorative items (such as vases, wall art, etc.). Items such as a personal computer or laptop may be purchased if needed by the participant for health and welfare purposes: connecting with disability support groups, making medical appointments, purchasing supplies or groceries, searching for and arranging transportation services, accessing weather alert information, attending classes, conducting employment searches or activities, etc. Items like computers cannot be purchased for recreational and/or entertainment use – MFP funds are intended to enhance the participant's health and well-being, and purchase decisions should be driven by need, not want. These items are intended for use by or for the participant, and are not intended to replace or upgrade the existing items in the home of a relative. However, it may be necessary to purchase items to supplement those available in the home of a relative in order for the participant to have items available for their own use.

Rate: This service provides a maximum of \$750 to be used during the 365 day demonstration period. The purchase of groceries is limited to a one-time purchase not to exceed \$200. While this service is intended as a one-time start up service to help the participant establish a qualified residence, it is recognized that these funds may need to be used throughout the year in certain circumstances.

Further Guidance on Household Furnishings and Household Goods and Supplies for Participants in PCHs

ORS regulations require that Personal Care Homes provide certain basic furnishings to all residents (please see <http://ors.dhr.georgia.gov/portal/site/DHR-ORS/menuitem.a7e86d3fa49a7a608e738510da1010a0/?vgnnextoid=adbfc353024f1010VgnVCM100000bf01010aRCRD> for the Rules and Regulations for Personal Care Homes). However, there are additional items that may be necessary to improve the health, safety and well-being of the participant while living in the PCH, such as a wardrobe for storing clothes and personal belongings or a desk for preparing work for school or employment. If these items were not identified during the initial ITP meeting, TCs forward requests for additional furnishings to the DCH MFP Office along with appropriate justification, using the *MFP Request for Additional Services* and *MFP Authorization for Services* forms.

708 Moving Expenses

Description: This service provides assistance to participants who need to have their belongings moved to their qualified residence in the community, either from storage, the home of a family or friend, or from the place of purchase.

How It Works: During planning, TCs invite members of the participant's circle of support to assist the participant on moving day, either through the use of their personal vehicles or by providing labor for moving. This service can then be arranged to obtain a truck rental, the services of a moving company, or delivery fees associated with newly purchased goods, as appropriate.

Rate: There is a maximum of \$750 to be used during the 365 day demonstration period. While this service is intended as a one-time start up service to help the participant establish a home, it is recognized that these funds may need to be used throughout the year in certain circumstances.

709 Utility Deposits

Description: This service provides assistance to participants who need to pay utility deposits to set up their new residence.

How It Works: These funds can be used to turn on electricity, gas, water, telephone, and cable and Internet service. These funds can be used to pay past due utility bills in order to reconnect services.

Rate: The maximum allowed for utility deposits is \$500 in the 365 day demonstration period. Refer to Section 605.7 for further information on arranging for the payment of utility deposits.

710 Security Deposits

Description: Once a qualified residence has been identified, TCs assist participants with securing the qualified residence using MFP funds for application fees and security deposits.

How It Works: These funds can be used to pay the security deposit (flat fee, first and last month's rent, etc.) and/or application fees required to secure a rental unit that meets the qualified residence criteria.

Rate: The maximum allowed cost for security deposits is \$1,000 in the 365 day demonstration period. Refer to Section 605.7 for further information on arranging for the payment of security deposits.

Rev. 01/10

711 Transition Support

Description: This service provides funding for needs that are unique to each participant but necessary for a successful transition.

How It Works: These funds may be used to help participants resolve transition barriers that may be unique to each participant. For example, a participant may need to obtain a birth certificate or other necessary documentation that requires a fee, or the participant may need assistance to pay a rental unit application fee.

Such needs are determined with the participant during planning. The TC works with the participant to resolve the identified issues. In some instances, participants may have a need for additional funding in one of the other MFP transition services categories. For instance, a participant may have a past due electric bill that must be paid in order to have electricity turned on. If the amount of the past due electric bill and deposit depletes the funding available in the Utility Deposits category, the participant has no funds left to pay deposits for water, sewage, gas, etc. The participant will need additional funds to cover the deposits necessary to have the other utilities turned on. Funds in the Transition Support category can be used for this purpose. Note that these funds are to be used in this manner only when doing so directly supports the participant's transition. These funds cannot be used to purchase more items than might otherwise be obtained, such as purchasing more than the category limit on Household Furniture or Household Goods. Participants and TCs work carefully to develop a budget for obtaining those items and stay within the existing budget. In addition, these funds cannot be used for categories where funding still remains. Expenses in this category must be authorized by DCH on a case-by-case basis, and unauthorized purchases, or purchases that violate the guidelines within other service categories, will not be reimbursed.

Rate: This service is limited to \$600 in the 365 day demonstration period.

712 Transportation

Description: This service assists participants with gaining access to community services and the resources required during transition, and is used when other transportation options are not available.

How It Works: This service does not replace Non-Emergency Transportation (NET) or emergency ambulance services. Transportation funds can be used for trips related to transition, such as making trial visits to the community, viewing housing options and personal care homes to find a suitable, qualified residence, obtaining needed documents such as personal identification, and for going home on the date of discharge.

Rate: One unit = \$25.00 one-way or \$50 round trip, up to \$500 per member, can be a pre-transition service, ends on day 365 of the MFP demonstration period..

713 Skilled Out-of-Home Respite

Description: This service provides for a brief period of support or relief for non-paid caregivers or family members who are caring for an MFP participant.

How It Works: This service is provided by a qualified Georgia nursing facility or community respite provider.

Rate: One unit = \$134.17 per day, limited to 14 units or \$1,878.38 per member, ends on day 365 of the demonstration period.

714 Caregiver Training

Description: This service provides training and education to individuals who support or provide companionship to MFP participants.

How It Works: This training can be provided to live-in non-paid caregivers (family or friends) or family members or friends who will be providing daily care for the participant. The training may be used to train the caregiver on providing safe transfers, bathing, equipment care or other issues unique to the participant's needs. Caregiver training is available through local Independent Living Centers and other local agencies.

Rate: There is a maximum of \$30 per hour (one unit), up to 40 hours, to be provided during the 365 day demonstration period.

715 Long-Term Care Ombudsman Services

Description: This service provides a monthly contact for review of a participant's health and safety and adjustment to the community following discharge.

How It Works: The Ombudsman program follows participants in the Atlanta, Augusta, and Northwest Georgia regions who transition into the CCSP, SOURCE, and ICWP waivers. This service is not available to participants who transition to other areas of the state, participants who transition into other waivers, or participants who transition into Personal Care Homes (Ombudsmen make regular visits to residents of Personal Care Homes as a part of their regular function).

Rate: The maximum allowed for Ombudsman services is \$150 per contact (one unit) for up to 12 contacts per participant throughout the 365 day demonstration period. This service is initiated at the request of the participant.

716 Equipment and Supplies

Description: This service provides equipment and supplies that are not otherwise covered under Medicaid and/or Medicare.

How It Works: These funds can be used to obtain identified equipment, durable medical equipment, adaptive or assistive technology devices, services, and supplies needed to enable to participant to interact more independently, enhancing their quality of life and reducing their dependence. This service does not cover the purchase of ongoing supplies (such as Depends, etc.) that the participant will be expected to obtain on a regular basis throughout and after the MFP period.

Rate: There is a maximum of \$5,000 available during the 365 day demonstration period.

Further Guidance on Medicaid/Medicare Coverage of Equipment and Supplies

If the item to be obtained is clearly not covered through Medicaid and/or Medicare, TCs do not need to provide documentation to the DCH MFP Office of a Medicaid or Medicare denial for the item (follow the link to

https://www.ghp.georgia.gov/wps/output/en_US/public/Provider/MedicaidManuals/2009-07_DME_v4.pdf for guidance on Georgia's Medicaid DME coverage).

If the item is normally covered through Medicaid or Medicare and the participant has received a denial (they are requesting a non-covered component, they may benefit from the item but do not have a letter of medical necessity from their physician, etc.), the TC must provide a copy of this documentation to the DCH MFP Office in order to authorize the purchase.

If the item is only partially covered through Medicaid or Medicare, the TC authorizes the remaining cost to be paid using MFP funds and must provide documentation of the item's cost and the applicable coverage to the DCH MFP Office.

Further Guidance on Interim Equipment Needs

Some participants may not have access to a piece of Medicaid or Medicare covered equipment, such as a wheelchair, that is needed immediately upon discharge. They may be waiting for coverage approval, or they may be waiting on the delivery of their ordered equipment. In these circumstances, in order to allow the participant to successfully transition on the desired date, MFP funds can be used to cover equipment for use on an interim basis.

TCs assist the participant in working with refurbished DME suppliers such as FODAC or rental DME dealers to obtain the needed equipment for a specified duration. When the ordered equipment has been delivered to the participant, the temporary MFP-funded equipment is returned to the vendor. If the ordered equipment takes longer to be delivered than originally identified, the temporary period can be extended to accommodate the participant's need for such equipment, as long as MFP funds are available to support the extension.

Using the Quote Form for Equipment and Supplies

Three quotes are required for the purchase of a single piece of equipment that costs \$1000 or more. TCs assist participants in obtaining quotes for the needed equipment.

TCs complete the *Quote Form for Equipment & Supplies, Environmental Modifications and/or Vehicle Adaptations* (see Appendix T). Participant information is completed in the top section of the *Quote Form*. In the table provided, list the three quotes from the three unique vendors. Include the quoted amount and check the quote selected. If a quote is selected that is not the lowest quote, provide a justification for the selected quote. The TC must sign the form to authorize the equipment purchase. Supporting documentation includes the quotes from vendors. Send the completed *Quote Form* to Acumen via File Transfer Protocol (FTP) and the DCH/LTC MFP office via FTP or secure fax.

717 Vehicle Adaptations

Description: This service provides funding to assist participants to pay for vehicle adaptation to a vehicle that is privately owned by the participant or their family.

How It Works: The TC assists the participant to obtain three quotes for the needed adaptations. Vehicle adaptations include the installation of driving controls (when applicable), a lift or ramp for wheelchair or scooter access, wheelchair tie-downs and occupant restraints, special seats or other modifications that are needed to provide for the safe access into and out of and operation of the vehicle. This service does not cover repairs to the vehicle or to the adaptations once they are installed and operational.

Rate: There is a maximum of \$6,240 available during the 365 day demonstration period. Three quotes must be obtained for all vehicle adaptations. Refer to Section 605.6 for instructions on completing the quote form. Additionally, if the owner of the vehicle is not the participant, a notarized letter giving the owner's permission for the adaptations must be obtained.

718 Environmental Modifications

Description: This service provides funding to assist participants to make physical adaptations to their homes or to a family home where they are residing. These services can also be used to make modifications to rental units funded by Housing Choice Vouchers and to community homes on a case-by-case basis.

How It Works: The services can pay for such things as ramps, structural changes such as widening doorways, the purchase and installation of grab-bars and bathroom modifications. These modifications are done to improve or maintain the independence of the participant in ADLs and to ensure health, welfare and safety. Modifications are not intended for cosmetic upgrades or repairs of existing issues within the home. Three quotes are required for all home modifications. Quotes from contractors must be based on using standard materials. Luxury materials (such as marble, brass, designer tiles, etc.) will not be covered by this service. Any materials used beyond basic/standard materials will be subsidized by the property owner. Refer to Section 605.5 for instructions on completing the quote form. Additionally, if the property owner is not the participant, a notarized letter giving the owner's permission for the modifications must be obtained.

Rate: There is a maximum of \$8,000 available during the 365 day demonstration period.

Further Guidance on Home Ownership for Environmental Modifications

When the participant or their family member has a contract in place to rent- or lease-to-own their home, they must provide the TC with a copy of the lease-to-own agreement and signed notarized letters granting permission for the modifications from both the current property owner and the lessee. The TC sends these documents to the DCH MFP Office along with the quote form and authorization.

CHAPTER 800

PARTICIPANT RECORDS

801 Records Administration

Working with field-based Transition Coordinators (TCs), MFP manages participant records using a secure file transfer protocol and a computerized participant tracking database. The **MFP Participant Tracking Database** is used to enter, archive and retrieve participant records. This chapter includes instructions for accessing the MFP Secure Transfer Protocol site, for transferring secure documents to the MFP Office. This chapter concludes with a review of the **MFP Participant Tracking Database** and record keeping processes and standards.

802 Secure Transfer Protocol for MFP Documentation

Instructions for Accessing the DCH File Transfer Protocol Server (FTP Secure File Transfer) Using a Secure Client That Supports SFTP/SSH

1. If the TC/contractor already has an external source installed on her/his computer/network/server, go to STEP 10.
2. If your external source does not have a client, FileZilla can be downloaded and installed for free from the following site: <http://filezilla-project.org/download.php>.
3. Save the version that supports your operating system to your desktop
4. Double-click downloaded file and install
5. Once application opens for installation, ACCEPT license agreement.
6. Then CHECK button for anyone who uses this computer. CLICK next.
7. You will be prompted to Select components to be installed. CHECK FileZilla Client and Desktop Icon.
8. Then CLICK next to install in your program files.
9. Finally click FINISHED
10. Once the FileZilla or other third party secure FTP client has been installed, open icon from desktop.
11. When application opens, click FILE
12. Then click SITE MANAGER
13. Once you click Site Manager- you will be prompted to enter DCH FTP server information. Click NEW SITE.

You will need to contact the DCH Application Administrator (Angela Carthan at 404-656-0727) to obtain the following: Host, Port, Login Type, User Name and Password. Once you have obtained these, you will be able to complete the setup of the FTP Secure File Transfer. Once operational, TCs use the FTP to submit all requested documents to DCH/LTC MFP Office.

803 MFP Participant Tracking Database

MFP participant records are captured and maintained in the **MFP Participant Tracking Database**. The tracking database contains participant header demographic information and 11 screens/tabs. The database includes searchable features.

MFP Participant Tracking Database:

1. Tracks and manages demographic and service authorization information for all MFP participants.
2. Tracks statewide service authorizations for MFP services
3. Generates reports on service authorization and service activities

DCH/LTC, MFP office staff enters, verifies and retrieves data and generates reports using the **MFP Participant Tracking Database**. TCs are responsible for submitting the following completed MFP forms necessary for creation of the participant profile, tracking service authorizations and generating reports:

- *Authorization for Use or Disclosure of Health Information* (see Section 602.4 and Appendix D1)
- *MFP Consent for Participation* (see Section 602.4 and Appendix D2)
- *MFP Transition Screening Form* (see Section 602.6 and Appendix G)
- *Quality of Life Survey* (see Section 602.8)
- *Individualized Transition Plan (ITP)* (see Section 604.2 and Appendix Q1, Q2)
- *Discharge Day Checklist* (see Section 604.4 and Appendix R)
- *Authorization for MFP Services* (see Section 604.3 and Appendix S)
- *Quote Form for Equipment & Supplies, Environmental Modifications and/or Vehicle Adaptation* (see Section 605.5 and Appendix T)
- *Vendor Payment Request to TC* (see Section 604.3 and Appendix U)
- *Vendor Import File* (see 604.3 and Appendix V)
- *Request for Additional MFP Services* (see Section 606.2 and Appendix X)
- *Participant Enrollment Status Change Form* (see Section 604.5, 606.3 and Appendix Y)
- *Referral for Housing Choice Voucher* (see Section 605.4 and Appendix AA)
- *MFP Sentinel Event Report* (see Section 603.3 and Appendix AB)

Summary-tab captures the ‘top’ information from each of the other Screens/Tabs (Screener, Personal, Housing, Financial, Health Needs, etc.) in the manual tracking database. Summary records cannot be added or updated until after the Member Heading, Screener Tab and Personal Tab have been completed.

MFP Transition Screening Form

MEMBER

Georgia Medicaid Id: Medicare Id: SSN:

Name (First MI Last): Birth Date:

Status:

Final Waiver Assignment:

Total Expenditures:

Initial MFP Referral Date:

Initial Screening Date:

ITP Meeting Date:

Initial Discharge Date:

Projected MFP End Date:

Facility Name	Admission Date	Discharge Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Record: 1 of 1

Record: 164 of 164

Form View

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start

2 Microsoft ...

Secure MFP

Janice MFP Da...

DRAFT_MFP_P...

Money Follows...

MFP

2:31 PM

Screener-tab captures essential information from the *MFP Transition Screening Form* (see Appendix G) about eligibility criteria, participant demographics, referral source and language spoken by the participant.

MEMBER

MFP Transition Screening Form

Georgia Medicaid Id: Medicare Id: SSN:
 Name (First MI Last): Birth Date:

Summary **Screener** Personal Housing Financial Health Needs Functional Needs HCBS Recs Documentation Transition Funding Notes

SCREENING

Does member wish to live outside facility? YES

Initial Screen Date:
 Rescreening Dates:

REFERRAL

Referral Source:
 Referral Phone:
 Referral Date:
 Screener Name:

DEMOGRAPHIC

Gender:
 Ethnicity:
 Population Code:
 Program Referred To:

LANGUAGE

Primary Language: English
 Hearing Disability: Needs Interpreter:
 Interpreter Name:
 Interpreter Phone:

Has member resided in institution/facility at least 180 days? YES

Record: of 164

Form View NUM

start | Microsoft Office ... | 2 Windows Explorer | DRAFT_MFP_PP_M... | Money Follows Pers... | MFP | 2:31 PM

Personal-tab captures information about where the participant currently resides, marital status/spouse contact, guardian information, background information and family contacts.

Microsoft Access - [MFP]

File Edit View Insert Format Records Tools Window Help

Tahoma 10 B I U

Type a question for help

MFP MEMBER

MFP Transition Screening Form

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Medicaid Id: [] Medicare Id: [] SSN: []

Name (First MI Last): [] [] [] Birth Date: [] [] []

CURRENT FACILITY

Current Facility Name: []

Discharge Contact Name: []

Discharge Contact Phone: []

Current Facility Type: Nursing Facility []

Other Facility Type: []

MARITAL STATUS / SPOUSE CONTACT

Marital Status: []

Name: []

Address: []

Address: []

City St Zip: [] [] []

GUARDIAN

Name: []

Address: []

Address: []

City St Zip: [] [] []

Phone: []

MISCELLANEOUS BACKGROUND INFORMATION

Veteran: YES Wartime Service: YES

Prior Residence: []

Reason for Entering: []

Current Facility: []

Time member has been in current facility: Yrs: [0] Mos: [0]

ADDITIONAL TRANSITION CONTACTS

Name	Phone
[]	[]
[]	[]
[]	[]

FAMILY

Does member have family in area? YES

Name: []

Address: []

Address: []

City St Zip: [] [] []

Phone: []

Record: [] of 164

Form View NUM

start 2 Microsoft Office ... 2 Windows Explorer DRAFT_MFP_PP_M... Money Follows Pers... MFP 2:32 PM

Housing-tab captures information about the participant’s need for housing, qualified housing choice, and if the participant has a preference for living with a roommate. Tab also captures information on in-home services used before the participant entering the nursing facility and if the participant is currently list for in-home (HCBS) wavier services.

The screenshot displays a Microsoft Access database window titled "Microsoft Access - [MFP]". The main form is titled "MFP Transition Screening Form" and is associated with the Georgia Department of Community Health. The form is divided into several sections:

- MEMBER**: Contains fields for Georgia Medicaid Id, Medicare Id, SSN, Name (First MI Last), and Birth Date.
- EXISTING HOME**: Includes a question "Does member have a home to move into?" with a YES checkbox. It also asks "Are other people living in the home?" with a YES checkbox. Below these are fields for Name and Relationship, and address fields (Address, City St Zip).
- HOUSING and SERVICES**: Contains fields for Type of Housing Requested, Reason for Housing Choice, and a question "Does member want to live with someone in particular?" with a YES checkbox. It also includes fields for Name of person to live with, Phone, and Additional contact information. Other questions include "Did member receive in-home services prior to entering current facility?" (YES checkbox), "List in-home services used prior to entering current facility", "Is member on a Waiver waiting list for home or community-based services?" (YES checkbox), "Name of Waiver Waiting List", "Does member have a letter or contact information from the Waiver?" (YES checkbox), and "Location of Contact Letter".

The bottom of the window shows a record navigation bar with "Record: 164 of 164" and a taskbar with various applications open, including Microsoft Office, Windows Explorer, and Money Follows Pers... The system clock shows 2:32 PM.

Financial-tab captures information about the participant's financial resources available for community living.

MFP MEMBER

MFP Transition Screening Form

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Medicaid Id: Medicare Id: SSN:

Name (First MI Last): Birth Date:

FINANCIAL RESOURCES

Description of Income	Amount	Payee
<input type="text"/>	\$0.00	<input type="text"/>
<input type="text"/>	\$0.00	<input type="text"/>
<input type="text"/>	\$0.00	<input type="text"/>
<input type="text"/>	\$0.00	<input type="text"/>
<input type="text"/>	\$0.00	<input type="text"/>
<input type="text"/>	\$0.00	<input type="text"/>
<input type="text"/>	\$0.00	<input type="text"/>

Description of Other Income

Description of Other Income	Amount
<input type="text"/>	\$0.00
<input type="text"/>	\$0.00

Person Responsible for Current Facility Expenses:

Is member Medicaid eligible but subject to transfer of asset penalty? YES

Record: 164 of 164

Form View

start Microsoft Office ... Windows Explorer DRAFT_MFP_PP_M... Money Follows Pers... MFP 2:32 PM

Health Needs-tab captures self-reported diagnosis, current physician contact information and DME/Assistive Technology used by the participant and the condition of this equipment.

MFP Transition Screening Form

MEMBER

Georgia Medicaid Id: Medicare Id: SSN:

Name (First MI Last): Birth Date:

SELF-REPORTED DIAGNOSIS

Diagnosis:

Diagnosis:

Diagnosis:

Diagnosis:

Diagnosis:

Diagnosis:

Diagnosis:

Diagnosis:

PHYSICIAN CONTACT

Facility Physician Name:

Does member have a Primary Care Physician outside facility? Yes

PCP Name:

PCP Phone:

Does member need help administering his/her medication? Yes

Description of Assistance Needed Administering Medication:

DME / ASSISTIVE DEVICES

Description of Device	Owns	Needs Repair	Needs To Be Replaced	Needs or Does Not Own
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Record: 164 of 164

Form View

NUM

start | Microsoft Office ... | Windows Explorer | DRAFT_MFP_PP_M... | Money Follows Pers... | MFP | 2:33 PM

Functional Needs-tab captures basic information about the need for assistance in the community. To qualify for MFP, the participant must have at least one unmet need. Tab captures TCs comments and observations, DME and AT used.

MFP Transition Screening Form

MEMBER

Georgia Medicaid Id: Medicare Id: SSN:

Name (First MI Last): Birth Date:

Does member have impaired abilities? Check box if yes.	Is need unmet after return to community? Check box if yes.	Comments
Eating <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bathing <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Grooming <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Dressing <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Transferring <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Continenence <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Money Mgmt <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Telephone <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Meal Preparation <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Laundry <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Housework <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Outside Home <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Routine Health <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Special Health <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>
Being Alone <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>

Record: 164 of 164

Form View NUM 2:33 PM

HCBS Recs-tab captures the TCs recommendation for HCBS waiver referral, dates of referral, application submission and waiver assessment completion date. Also captures the reason for refusal to participant in MFP, given by the participant.

The screenshot shows a Microsoft Access database window titled "Microsoft Access - [MFP]". The main form is titled "MFP Transition Screening Form" and is part of the "MEMBER" database. The form is divided into several tabs: Summary, Screener, Personal, Housing, Financial, Health Needs, Functional Needs, **HCBS Recs**, Documentation, Transition Funding, and Notes. The "HCBS Recs" tab is currently selected.

At the top of the form, there are input fields for:

- Georgia Medicaid Id: []
- Medicare Id: []
- SSN: []
- Name (First MI Last): []
- Birth Date: []

The "HCBS RECOMMENDATIONS" section contains a list of checkboxes for different service categories:

- Elderly and Disabled CCSP, AAA/Gateway
- SOURCE AAA/Gateway
- Independent Care ICWP, GMCF
- NOW Regional MHDDAD Office
- COMP Regional MHDDAD Office
- Non-Medicaid HCBS

Below these checkboxes are several text input fields:

- Recommendations for Other Services: []
- HCBS Application / Referral Date: []
- HCBS Application Submission Date: []
- HCBS Assessment Completion Date: []
- Reason for Refusal to Participate: []

The bottom of the window shows a record navigation bar with "Record: 164 of 164" and a "Form View" indicator. The Windows taskbar at the bottom shows the Start button and several open applications, including Microsoft Office, Windows Explorer, and the MFP application.

Documentation-tab captures information about the documents submitted and maintained on the MFP participant.

MFP Transition Screening Form

MEMBER

Georgia Medicaid Id: Medicare Id: SSN:

Name (First MI Last): Birth Date:

DOCUMENT CHECKLIST		
Description	On File	
MFP Consent to Participate	<input type="checkbox"/>	Is other documentation available on file? YES <input type="checkbox"/>
Authorization for Use of Information	<input type="checkbox"/>	Description: <input type="text"/>
Current Medication List	<input type="checkbox"/>	Description: <input type="text"/>
Copy of Georgia Medicaid Card	<input type="checkbox"/>	
Copy of Medicare Card	<input type="checkbox"/>	
Copy of Social Security Card	<input type="checkbox"/>	
Copy of Guardianship Documents	<input type="checkbox"/>	
Power of Attorney	<input type="checkbox"/>	

SUPERVISOR REVIEW DATA

Name:

Date:

Phone:

Email:

Record: 164 of 164

Form View

NUM

start | Microsoft Office... | Windows Explorer | DRAFT_MFP_PP_M... | Money Follows Per... | MFP | 2:34 PM

Transition Funding-tab capture the TCs authorization for transition services by category, description, actual date and actual amount authorized from the *Authorization for MFP Services* (see Appendix S). Tab also captures quotes for equipment, supplies, environmental mod and/or vehicle adaptations (see Appendix T).

MFP Transition Screening Form

MEMBER

Georgia Medicaid Id: Medicare Id: SSN:

Name (First MI Last): Birth Date:

Summary Screener Personal Housing Financial Health Needs Functional Needs HCBS Recs Documentation **Transition Funding** Notes

AUTHORIZED TRANSITION SERVICES

Transition Service Code, Category, Maximum Allowed Amount	Description of Transition Service	Auth Date	Auth Amount	Actual Date	Actual Amount
			0.00		0.00

Record: 1 of 1

QUOTES for EQUIPMENT and SUPPLIES, ENVIRONMENTAL MODIFICATIONS and/or VEHICLE ADAPTATIONS

Modification Type	Description of Modificaton	Vendor Name	Estimated Cost
			\$0.00

Record: 164 of 164

Form View

Notes-tab captures any notes on the case reported by the TC.

MFP Transition Screening Form

MEMBER

Georgia Medicaid Id: Medicare Id: SSN:

Name (First MI Last): Birth Date:

Summary Screener Personal Housing Financial Health Needs Functional Needs HCBS Recs Documentation Transition Funding **Notes**

MFP Notes

Date	User	Note
<input type="text"/>	<input type="text"/>	<input type="text"/>

Record: 164 of 164

Form View NUM

804 Record Keeping Standards

TCs maintain records on all individuals interviewed as well as all participants transitioned. All participant records, documents, and invoices must be maintained in their original hard copy for a minimum of seven (7) years after the final termination of the Contract to provide Transition Coordination for the Money Follows the Person demonstration grant.

APPENDIX A

DOCUMENTS AND INFORMATION NEEDED FOR HOUSING SEARCHES

Revised 7/31/09

TCs guide participants through the housing search using various tools. To the greatest extent possible, participants should be engaged in their housing search. Together with the TC, the participant must identify the following:

- A realistic budget – generally, 1/3 of the participant’s income is a guideline for housing expenses,
- Budget range for rent and utilities
- Living arrangement
- Needed household furnishings
- Utilities and security deposit amounts and when they are due
- Moving costs
- Housing modifications that may be needed
- Target date for moving

Depending on the participant’s preference of qualified residence, TCs assist participants to gather and organize documentation needed to complete rental applications, including:

- State issued ID (must be current)
- Birth Certificate
- Social Security card
- Proof of Income (e.g. bank statements, SSI/SSD award letter)

When searching for subsidized housing and/or submitting applications for rental assistance programs, TCs assist participants with the following:

- Obtaining and reviewing credit reports, correcting incomplete and inaccurate information
- Finding assistance to pay past unpaid utility bills
- Obtaining and reviewing criminal history/background reports
- Obtaining and organizing documents needed to complete rent-controlled and subsidized housing applications
- Obtaining utility information and connecting utilities

TCs familiarize themselves with local and regional housing availability based on the following broad category types:

- Affordable rental housing
- Low-income Housing Tax Credit (LIHTC)/private rental housing
- Non-subsidized affordable housing (by county)
- Affordable housing for older adults (HUD 202)
- Subsidized housing (HUD 811)
- Public housing through Public Housing Authorities (PHAs)
- Roommate/Housemate matching assistance programs
- Personal Care Homes, Assisted Living Facilities and Community Living Arrangements (Host Homes) that meet qualified resident guidelines

TCs familiarize themselves with the following terms used in housing searches:

- **Area Median Income (AMI)**-refers to the middle or midpoint income for a particular area. The term is used to estimate the "average" income for a particular area.
- **Affordable Housing**-is a vague term generally defined as housing where the occupant pays no more than 30% of gross income for total housing costs, including utilities.
- **Public Housing**-is housing that a Public Housing Authority operates. A criminal background check is required in all Public Housing buildings.
- **Public Housing Agency (PHA)**-is a public agency created by state or local government to finance or operate low-income housing.
- **Housing Choice Vouchers (formerly Section 8)**-is a federally funded rent subsidy program for low income persons. Local public housing authorities (PHA) receive funds from HUD to administer the Housing Choice Program. PHAs determine eligibility for the program and the amount of the rental assistance. The renter is required to pay 30% of her/his adjusted income for rent. If the PHA determines that the renter/family is eligible, it will issue a rental voucher or certificate. The renter is responsible for finding a suitable rental unit. The rental unit must meet minimum standards for health and safety, as determined by the PHA.
- **Based On Income (BOI)**-means that rent will be (in most cases) 30% of adjusted gross monthly income.
- **Single Room Occupancy (SRO)**-is a building in which tenants occupy single private spaces, but share cooking facilities and/or bathrooms. Generally known as a boarding house, this type of housing does not meet MFP qualified residence requirement.

APPENDIX B

Medicaid Rate	Pre-Transition Services	Procedure Code	Modifiers	Rate	Description
Enhanced	Peer Community Support	T2038	Q2, U1	1 unit = \$30.00 per hour, limited to 40 hours or \$1,200 per member - ends on day 365 of the MFP demonstration period.	This service provides assistance to participants to network and build connections to individuals and associations in their local community.
Enhanced	Trial Visit-Personal Support Services/PCH	T2038	Q2, U15	1 unit of personal support = the current rate provided by the appropriate waiver, limited to 74 hours for ICWP and 55 hours for CCSP and SOURCE (not to exceed \$1044 per member). 1 unit of residential services = 1 day at \$65 per day, limited to 5 days (\$325). Ends on day 365 of the MFP demonstration period.	This service provides a brief period of personal support services or residential services (such as a personal care home) during a trial visit to the community before transitioning. The purpose of this service is to give the participant an opportunity to manage and direct Personal Support Services (PSS) staff and/or interact with staff in the personal care Home.
Enhanced	Household Furnishing	T2038	Q2, U6	Limited to \$1,500 per member - ends on day 365 of the MFP demonstration period.	This service provides assistance to participants requiring basic household furnishings (e.g., bed, table, but not limited to items listed) to help participants transition back into the community. This service is intended to help the participant with the initial set-up of their qualified residence.
Enhanced	Household Goods and Supplies	T2038	Q2, U5	Limited to \$750 per member - ends on day 365 of the MFP demonstration period.	This service provides assistance to participants requiring basic household goods (e.g., cookware, toiletries). This service is intended to help the participant with the initial set-up of their qualified residence. This service may include a one-time purchase of groceries (up to \$200) to assist a participant with setting up their qualified residence.
Enhanced	Moving Expenses	T2038	Q2, U7	Limited to \$750 per member - ends on day 365 of the MFP demonstration period.	This service includes rental of a truck and staff, moving or delivery service, to move the participant's goods into a community setting. This service is intended to help the participant with the initial set-up of their qualified residence.
Enhanced	Utility Deposits	T2038	Q2, U8	Limited to \$500 per member- ends on day 365 of the MFP demonstration period.	To assist participants with utility deposits to help consumers transition back into the community.
Enhanced	Security Deposits	T2038	Q2, U9	Limited to \$1,000 per member- ends on day 365 of the MFP demonstration period.	To assist participants with housing application fees and deposits to help consumers transition back into the community.
Enhanced	Transition Support	T2038	Q2, U10	Limited to \$600 per member - ends on day 365 of the MFP demonstration period.	This service provides assistance to help participants with unique service needs during transition (obtaining documentation, accessing paid roommate match services, etc.). This service is intended to support transition only, and expenses will be authorized on a case-by-case basis.
Regular	Transportation	T2038	Q2, U4	1 unit = \$25 one way or \$50 per trip up to \$500 per member - ends on day 365 of the MFP demonstration period.	This service enables participants to gain access to community services and resources required for transition (i.e. housing). This is provided as a service when transportation is not otherwise available. This service does not replace the Medicaid non-emergency transportation (for medical appointments) or emergency ambulance services.

Medicaid Rate	Post Transition Services	Procedure Code	Modifiers	Rate	Description
Enhanced	Skilled Out-of-Home Respite	T2038	Q2, U2	1 unit = \$134.17 per day, limited to 14 units or \$1,878.38 per member - ends on day 365 of the MFP demonstration period.	This service provides a brief period of support or relief for caregivers or family members caring for an elderly or disabled individual. This service will pay for up to 14 days during the MFP 365 day demonstration. The respite is done at a GA qualified nursing facility or community respite provider approved through a Georgia waiver program.
Enhanced	Caregivers Training	S5110	Q2	1 unit = \$30.00 per hour, limited to \$1,200 per member - ends on day 365 of the MFP demonstration period.	Services to provide training and education to individuals who support or provide companionship or supervision to participants. Not provided in order to train paid caregivers.
Enhanced	Ombudsman (LTCO)	T2038	Q2, U3	1 unit = \$150 per contact, limited to \$1,800 per member - ends on day 365 of the MFP demonstration period.	This service provides a monthly contact for review of a transitioned participants' health, welfare and safety and adjustment in the community - limited to participants in CCSP, SOURCE and ICWP who transition into a home or apartment (excludes residential setting).
Enhanced	Equipment and Supplies	T2038	Q2, U11	Limited to \$5,000 per member- ends on day 365 of the MFP demonstration period.	This service can provide equipment that is not otherwise covered by Medicaid. It might include certain types of assistive technology and services, bath chairs, communication systems, customized molded chair seats or environmental control systems to enable individuals to interact more independently, enhancing their quality of life and reducing their dependence.
Enhanced	Vehicle Adaptations	T2038	Q2, U13	Price of the lowest quote, limited to \$6,240 per member- ends on day 365 of the MFP demonstration period.	This service enables individuals to interact more independently, enhancing their quality of life and reducing their dependence. Limited to participant's or the family's privately owned vehicle and includes such things as hydraulic lift, ramps, special seats and other interior modifications for access into and out of the vehicle as well as to improve safety while moving.
Enhanced	Environmental Modification	T2038	Q2, U14	Price of the lowest quote, limited to \$8,000 per member- ends on day 365 of the MFP demonstration period.	This service provides assistance to participants requiring physical adaptations to the home that they own or that a family member owns where they are residing. Funds can also be used to modify a qualified residence used by participants in the Housing Choice Voucher program or to modify a community home on a case-by-case basis. This service could pay for such things as ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications, to ensure participants' health, welfare and safety and to assist with their ADLs.
					Maximum Post-transition cost
Enhanced match 87/13		Regular match 74/26			
MFP service procedures are based on approved services as specified in the participant's service plan.					
Q2-HCFA/ORD demonstration project procedures / service					
U- Medicaid Level of Care (1 thru 12), as Defined by each state					

APPENDIX C

What is Person-Centered Planning?

Transition plans work best when you fully participate in planning your own life. With person-centered planning, you will be asked to talk about your goals, needs, resources, personal experience and motivation to relocate.

You will also ask other people in your life to be part of your transition. Everyone depends on others at times. Through the MFP project, you will learn who these important people are and you will build more relationships with new people who share qualities that are important to you.

What are Home Modifications?

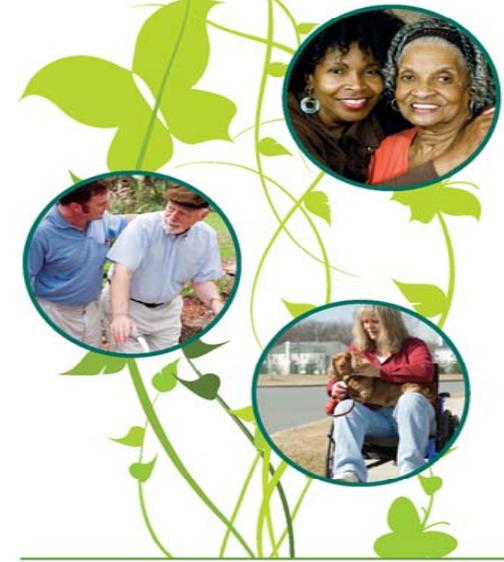
You may need assistance to live independently in your own home. This could be in the form of grab bars, knee space under sinks, lower closet shelves, ramps, widened doorways, switch-activated door openers and locks, or non-slip floors. Money Follows the Person includes financial help for eligible older adults and persons with disabilities to make these changes to existing structures. Contact your MFP Transition Coordinator for more details.

What is Self-Direction?

Self-direction is a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. They can assess their own needs, determine how and by whom these needs should be met and monitor the quality of services received.

Money Follows the Person Project
Georgia Department of Community Health
Georgia Department of Human Resources
Two Peachtree Street, NW, 37th Floor
Atlanta, GA 30303
Phone: 404-657-9323
Email: gamfp@dch.ga.gov
dch.georgia.gov/mfp

Money Follows the Person



Voice: 404-657-9323 | Email: gamfp@dch.ga.gov

Money Follows the Person is a five-year, \$56 million demonstration grant (Award #1LICMS030163/01) funded by the Centers for Medicare & Medicaid Services in partnership with the state of Georgia Department of Community Health.





"There's no place like home."
Dorothy in *The Wizard of Oz*

What is Money Follows the Person?

If you have lived in a nursing facility or an intermediate care facility for people with developmental disabilities for at least three months (with some exceptions) and would rather live in your own home or a group setting, you may be eligible for **home and community-based services** through Georgia's Medicaid programs.

You have a choice to stay in the institution or resettle in the community with home and community-based services.

Who will help me relocate?

If you want to move into your own place (home or apartment), you can take advantage of home and community-based services (HCBS). Transition Coordinators and peer supporters can help you learn the skills you need and provide you with help to relocate through a new grant offered through the Centers for Medicare and Medicaid Services (CMS) and the Georgia Department of Community Health (DCH) called Money Follows the Person (MFP).

What MFP services are available?

- Peer Community Support
- Trial Visits to the Community
- Household Furnishings
- Household Goods and Supplies
- Moving Expenses
- Utility Deposits
- Security Rent Deposits
- Transition Supports
- Transportation
- Skilled Out-of-Home Respite
- Caregivers Training
- Ombudsman Visits
- Equipment and Supplies
- Vehicle Adaptations
- Environmental Modifications

Who do I contact?

If you are interested and want more information on Money Follows the Person, you can contact:

- The Georgia Department of Community Health Money Follows the Person project at 404-657-9323,
- The Department of Human Services Division of Aging Services at 866-55-AGING (866-552-4464), or
- The Office of the Long Term Care Ombudsman at 404-656-6862, or
- Aging and Disability Resource Connections at 800-676-2433.

What are the Program Goals?

1. To increase the use of home and community-based, rather than institutional, long-term care services;
2. To eliminate barriers in state law, state Medicaid Plan and state budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible persons to receive support for long-term services in setting of their choice;
3. To increase the ability of the State to continue to provide home and community-based services to eligible people who choose to transition from an institution to a community setting.



dch.georgia.gov/mfp | Email: gamfp@dch.ga.gov

APPENDIX D1



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION



Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Member Name: _____

Medicaid Identification Number (MHN): _____

Health Plan Name: _____

Persons/Organizations authorized to *receive, use or disclose* the information ⁱ are:

MFP transition coordinators/case expeditors Representative (Legal, etc.)

Waiver assessment/case management staff MFP service providers

Purpose of requested use or disclosure: ⁱⁱ for screening and assessment and participation in the MFP Project.

This Authorization applies to the following information (select **only one** of the following).ⁱⁱⁱ

All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] **Except:** _____

Only the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

EXPIRATION

All information I hereby authorize to be obtained from this nursing facility/institution will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for: (PLEASE CHECK ONE)

ninety (90) days unless I specify an earlier date here: _____

one (1) year

the period necessary to complete all transactions related to my participation in the Money Follows the Person Project on matters related to services provided to me through the Money Follows the Person Project.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION



NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: _____

_____.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.^{iv}

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.^v

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

Signature of Member or Authorized Representative Date

If Signed by Representative, State Relationship or Basis of Authority

ⁱ If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

ⁱⁱ The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

ⁱⁱⁱ This form may not be used to release both psychotherapy notes and other types of health information (see 45 CFR § 164.508(b)(3)(ii)). If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.

^{iv} Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR § 164.508(d)(1), (e)(2)).

^v If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

APPENDIX D2



Money Follows the Person (MFP) Consent for Participation

I, _____, voluntarily agree to be screened and assessed as part of my application for participation in the Money Follows the Person (MFP) project. The MFP Transition Coordinator/Case Expediter will determine my appropriateness for the project. If approved for the MFP project, my participation may be in segments or consecutive days, but for a total period not to exceed 365 calendar days ¹.

By signing this Consent, I agree to participate in all aspects of the MFP project, including completing the *Quality of Life Survey*. My responses to the *Quality of Life Survey* and other program information will be shared with the Centers for Medicare and Medicaid Services (CMS) as well as Georgia and national evaluators.

I have been given information about the MFP project; a copy of the *Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia* and a copy of the *Participant Transition Planning Guide*. I understand the MFP project guidelines including enrollment requirements. I understand that MFP one-time transitional services are provided under a one-year demonstration project.

I understand that if I qualify for and am enrolled in an appropriate waiver program, waiver services will continue for as long as I need them and I continue to meet eligibility requirements. If I am no longer eligible for the Medicaid waiver program, I will be provided with other service options that may assist me in a community setting. I understand that certain circumstances will make me ineligible for a waiver and for MFP. If the total cost of providing my care under the waiver exceeds the cost of providing care in a hospital, nursing home or ICF, I will become ineligible for the waiver and for the MFP project. If my condition improves and I don't continue to meet the waiver Level of Care criteria, I will become ineligible for the waiver program and may become ineligible for the MFP project.

Date	Signature
-------------	------------------

If signed by Responsible Party, State Relationship and Authority to Sign

Date	Transition Coordinator/Case Expediter Sign
-------------	---------------------------------------------------

¹ If the MFP participant needs to be hospitalized for any reason during the MFP project for less than 30 days, the participant will not be considered an institutional resident. As soon as the participant's condition stabilizes, the participant can return to her/his place of residence in the community and resume MFP services. If the hospital stay is 30 days or longer, the participant will be discharged from MFP and will be considered an institutional resident. If the participant is re-admitted to a nursing home/institution for a stay of over 30 days, the participant will NOT need to meet another MFP 90 days institutional residency requirement, but will be re-evaluated for discharge to the community and re-enrolled into the MFP program. The MFP Transition Coordinator determines if any changes to the participant's Individualized Transition Plan are needed to prevent a re-admission to an institution. If the participant is hospitalized for a period of longer than six months, the participant will be re-evaluated like a "new" MFP participant.

MFP/DCH/DHR/DBHDD_Informed Consent_Revised_081110

APPENDIX E

How to Obtain the Booklet, HCBS, A Guide to Medicaid Waiver Programs in Georgia



**Booklet Order Form
Home and Community Services**

A Guide to Medicaid Waiver Programs in Georgia

Date: _____

Name of Facility/Individual:

Address: (Street Address Only—No P.O. Boxes)

Total Number of Booklets Requested: _____

Phone Number: _____

Fax Number: _____

RE: If you are a Nursing/ICF-MR facility, refer to section 802 of the Nursing Facility Services manual for ordering.

Fax to/Mail to:

Company: DCH/Long Term Care Unit

Fax Number: 404-656-8366

Mail to Attention: _____

**APPENDIX F
AREA AGENCY ON AGING**

Revised 12/01/2009

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Atlanta Region</p> <p>Cherokee Clayton Cobb DeKalb Douglas Fayette Fulton Gwinnett Henry Rockdale</p>	<p>Cathie Berger, AAA Director Atlanta Regional AAA 40 Courtland Street, N.E. Atlanta, GA 30303-2538 (404) 463-3100 Fax: (404) 463-3264 Aging Connection: 1-800-676-2433 or (404) 463-3333</p> <p>Email: cberger@atlantaregional.com</p> <p>Website: aginginfo@atlantaregional.com</p>	<p>Charles C. Krautler, Executive Director Atlanta Regional Commission 40 Courtland Street, N.E. Atlanta, GA 30303-2538 (404) 463-3100 Fax: (404) 463-3105</p> <p>Email: ckrautler@atlantaregional.com</p> <p>Fulton County</p>
<p>Central Savannah River Area</p> <p>Burke Columbia Glascocock Hancock Jefferson Washington Jenkins Lincoln McDuffie</p> <p>Richmond Screven Taliaferro Warren Wilkes</p>	<p>Jeanette Cummings, AAA Director Central Savannah River AAA 3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 (706) 210-2013 Director Direct Line (706) 210-2000 Aging Program Fax: (706) 210-2006 Aging Connection: 1-888-922-4464</p> <p>E-mail: jcummings@csrarc.ga.gov Website: www.csrarc.ga.gov</p>	<p>Andy Crosson, Executive Director Central Savannah River Area Regional Commission 3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 (706) 210-2000 Fax: (706) 210-2006</p> <p>E-mail: acrosson@csrarc.ga.gov</p> <p>Richmond County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Coastal Georgia</p> <p>Bryan Bulloch Camden Chatham Effingham Glynn Liberty Long McIntosh</p>	<p>Dionne Campbell (Interim AAA Director) Coastal Georgia AAA 127 F Street Brunswick, GA 31520 (912) 262-2822 Fax: (912) 262-2313 Information Link: 1-800-580-6860</p> <p>Email: dcampbell@crc.ga.gov</p> <p>Website: www.crc.ga.gov</p>	<p>Allen Burns, Executive Director Coastal Regional Commission of Georgia 127 F Street Brunswick, GA 31520 (912) 262-2800 Fax: (912) 262-2313</p> <p>Email: aburns@crc.ga.gov</p> <p>Glynn County</p>
<p>Georgia Mountains</p> <p>Banks Dawson Forsyth Franklin Habersham Hall Hart Lumpkin Rabun</p> <p>Stephens Towns Union White</p>	<p>Pat Freeman, AAA Director Legacy Link AAA P. O. Box 2534 Gainesville, GA 30503-2534 (770)538-2650 Fax: (770)538-2660 Intake Screening: 1-800-845-5465</p> <p>Physical Address: 508 Oak St., Ste 1, 30501</p> <p>E-mail: pvfreeman@legacylink.org</p> <p>Website: www.legacylink.org</p>	<p>Pat Freeman, Executive Director The Legacy Link, Inc. P.O. Box 2534 Gainesville, Georgia 30503-2534 (770) 538-2650 Fax: (770) 538-2660</p> <p>E-mail: pvfreeman@legacylink.org</p> <p>Hall County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Heart of Georgia Altamaha</p> <p>Appling Montgomery Bleckley Tattnall Candler Telfair Dodge Toombs Emanuel Treutlen Evans Wayne Jeff Davis Wheeler Johnson Wilcox Laurens</p>	<p>Gail Thompson, AAA Director Heart of Georgia Altamaha AAA 331 West Parker Street Baxley, GA 31513-0674 (912)367-3648 Fax: (912)367-3640 or (912)367-3707 Toll Free: 1-888-367-9913</p> <p>E-mail: thompson@hogarc.org</p> <p>Website: www.hogarc.org</p>	<p>Alan R. Mazza, Executive Director Heart of Georgia Altamaha Regional Commission 5405 Oak Street Eastman, Georgia 31023-6034 (478) 374-4771 Fax: (478) 374-0703</p> <p>E-mail: mazza@hogarc.org</p> <p>Dodge County</p>
<p>Middle Georgia</p> <p>Baldwin Peach Bibb Pulaski Crawford Putnam Houston Twiggs Jones Wilkinson Monroe</p>	<p>Geri Ward, AAA Director Middle Georgia AAA 175 Emery Highway, Suite C Macon, GA 31217-3679 (478)751-6466 Fax: (478)752-3243 Toll free: 1-888-548-1456</p> <p>E-mail: gward@mg-rc.org</p> <p>Website: www.mg-rc.org</p>	<p>Ralph Nix, Executive Director Middle Georgia Regional Commission 175 Emery Highway, Suite C Macon, GA 31217-3679 (478) 751-6160 Fax: (478) 369-6517</p> <p>E-mail: rnix@mg-rc.org</p> <p>Bibb County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Northeast Georgia</p> <p>Barrow Newton Clarke Oconee Elbert Oglethorpe Greene Walton Jackson Jasper Madison Morgan</p>	<p>Peggy Jenkins, AAA Director Northeast Georgia AAA 305 Research Drive Athens, GA 30610 (706)369-5650 Fax: (706)425-3370 Toll free: 1-800-474-7540</p> <p>E-mail: pjenkins@negrc.org</p> <p>Website: www.negrc.org</p>	<p>James R. Dove, Executive Director Northeast Georgia Regional Commission 305 Research Drive Athens, GA 30605 (706) 369-5650 Fax: (706) 369-5792</p> <p>E-mail: jdove@negrc.org</p> <p>Clarke County</p>
<p>Northwest Georgia</p> <p>Bartow Murray Catoosa Paulding Chattooga Pickens Dade Polk Fannin Walker Floyd Whitfield Gilmer Gordon Harralson</p>	<p>Debbie Studdard, AAA Director Northwest Georgia AAA P.O. Box 1798 Rome, GA 30162-1798 (706) 295-6485 Fax: (706) 295-6126 Toll Free: 1-888 -732-4464 Screening Fax: (706) 802-5506</p> <p>Physical Address: 1 Jackson Hill Dr. 30161</p> <p>E-mail: dstuddard@nwgrc.org</p> <p>Website: www.nwgrc.org</p>	<p>William R. Steiner, Executive Director Northwest Georgia Regional Commission P.O. Box 1793 Rome, GA 30162-1793 (706) 295-6485 Fax: (706)295-6126</p> <p>E-mail: wsteiner@nwgrc.org</p> <p>Floyd County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>River Valley</p> <p>Chattahoochee Quitman Clay Randolph Crisp Schley Dooley Stewart Harris Sumter Macon Talbot Marion Taylor Muscogee Webster</p>	<p>Tiffany Ingram, AAA Director River Valley AAA 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908 (706)256-2910 Fax: (706)256-2908 Toll Free: 1-800-615-4379</p> <p>E-mail: tingram@rivervalleyrcaaa.org</p> <p>Website: www.rivervalleyrc.org</p>	<p>Patti Cullen, Executive Director River Valley Regional Commission 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908 (706) 256-2910</p> <p>E-mail: pcullen@rivervalleyrc.org</p> <p>Muscogee County</p>
<p>Southern Georgia</p> <p>Atkinson Cook Bacon Echols Ben Hill Irwin Berrien Lanier Brantley Lowndes Brooks Pierce Charlton Tift Clinch Turner Coffee Ware</p>	<p>Wanda Taft, AAA Director Southern Georgia AAA 1725 South Georgia Parkway, West Waycross, GA 31503-8958 (912)285-6097 Fax: (912)285-6126 Toll Free: 1-888-732-4464</p> <p>E-mail: wtaft@sgrc.us</p> <p>Website: www.sgrc.us</p>	<p>John L. Leonard, Executive Director Southern Georgia Regional Commission 327 West Savannah Avenue P.O. Box 1223 Valdosta, GA 31603-1223 (229) 333.5277 Fax: (229) 333-5312</p> <p>E-mail: jleonard@sgrc.us</p> <p>Ware County</p>

<i>Planning & Service Area</i>	<i>AAA Director Name of AAA Address, Phone & E-Mail</i>	<i>Executive Director Name of Agency Address, Phone & E-Mail</i>
<p>Southwest Georgia</p> <p>Baker Lee Calhoun Miller Colquitt Mitchell Decatur Seminole Dougherty Terrell Early Thomas Grady Worth</p>	<p>Kay Hind, AAA Director SOWEGA AAA 1105 Palmyra Road Albany, GA 31701-1933 (229)432-1124 Fax: (229)483-0995 Toll free: 1-800-282-6612</p> <p>E-mail: khhind@dhr.state.ga.us</p> <p>Website: www.sowegacoa.org</p>	<p>Kay Hind, Executive Director SOWEGA Council on Aging, Inc. 1105 Palmyra Road Albany, GA 31701-1933 (229) 432-1124</p> <p>E-mail: khhind@dhr.state.ga.us</p> <p>Dougherty County</p>
<p>Three Rivers</p> <p>Butts Pike Carroll Spalding Coweta Troup Heard Upson Lamar Meriwether</p>	<p>Joy Shirley, AAA Director Southern Crescent AAA P.O. Box 1600 Franklin, GA 30217-1600 (706)407-0016 or (678)552-2853 Fax: (706) 675-9210 or (770)854-5402 Toll Free: 1-866-854-5652</p> <p>Physical Address: 13273 Hwy. 34 East</p> <p>E-mail: jyshirley@threeriversrc.com</p> <p>Website: www.scaaa.net</p>	<p>Lanier E. Boatwright Jr., Executive Director Three Rivers Regional Commission 120 North Hill Street P.O. Box 818 Griffin, GA 30224-0818 (770) 227-6300 Fax: (770) 227-6488</p> <p>E-mail: lboatwright@threeriversrc.com</p> <p>Spalding County</p>

APPENDIX G



Money Follows the Person (MFP) Transition Screening Form



Participant Name: _____

(Screener note: Establish rapport before beginning the screening process).

1. Do you want to live somewhere other than this facility? Yes No

Screening Type/Date: (Check only one box) <input type="checkbox"/> Initial F2F Screening _____ (mm/dd/yyyy) <input type="checkbox"/> F2F Re-screening _____ (mm/dd/yyyy)		Referral Source <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Self <input type="checkbox"/> Family Member <input type="checkbox"/> AAA/ADRC, CIL, etc. <input type="checkbox"/> Waiver Case Manager <input type="checkbox"/> Legal Representative <input type="checkbox"/> Other: (specify) _____		Date of Initial Contact by MFP: _____ (mm/dd/yyyy) Date of Referral To Waiver: _____ (mm/dd/yyyy)		Screener's Name: _____ Screener's Contact: _____	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian or Pacific Is. <input type="checkbox"/> Hispanic <input type="checkbox"/> Latino <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other: _____	Population (Check all that apply): <input type="checkbox"/> Older Adult (60+) <input type="checkbox"/> Physical Disability <input type="checkbox"/> ABI <input type="checkbox"/> DD <input type="checkbox"/> Other (specify): _____		Date of Birth _____ (mm/dd/yyyy)		Referral to: <input type="checkbox"/> CCSP <input type="checkbox"/> SOURCE <input type="checkbox"/> Independent Care Waiver <input type="checkbox"/> NOW <input type="checkbox"/> COMP <input type="checkbox"/> State Plan Service <input type="checkbox"/> Non-Medicaid HCBS <input type="checkbox"/> Other (specify): _____	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____				<input type="checkbox"/> Deaf or Hard of Hearing Requires Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: _____ Contract: _____			

(Screener Note: List persons participating in the screening or attach sign-in sheet).

Personal Data:

2. Medicaid # _____ Medicare # _____

3. First Name: _____ MI: _____ Last Name: _____

4. SSN: _____ -- _____ -- _____

5. Facility Name and Address: _____

City: _____, Zip: _____ Phone: _____

6. Discharge Planner/Contact: _____ Phone : _____

7. Marital Status: Single Mar Div Widowed Sep Other: _____



Money Follows the Person (MFP) Transition Screening Form



Participant Name: _____

8. Spouse Name and address: _____

9. Are you a veteran? Yes No. Did you serve during wartime? Yes No.

10. Do you have a guardian: Yes No If yes, list name and contact information:

(Screener note: Ask the person who they would like to include in the screening process—family members, friends, etc. If person has a guardian, stop the interview and reschedule the screening when these persons can participate).

Background Data:

11. Where did you live before you came here? _____

12. What were the reasons you entered this facility? _____

13. How long have you lived here at this facility? _____ years _____ months
(Screener note: to qualify for MFP, the person must have resided in the nursing facility/institution for a minimum of 90 days).

14. Do you have any family living in this area? Yes No
If yes, list name, phone number and address:

15. Do you have a close relationship with family member(s) or friend(s) that can assist you: Yes No

(Screener note: At this point in the interview, introduce, review and obtain signature on *Authorization for Release of Information* and *Informed Consent for MFP*).

16. May we contact a family member(s) or friends(s) to meet with you and us to discuss your move into the community? Yes No

17. If yes, please provide their name(s) and telephone number(s): _____

18. Do you have a home to move back into? Yes No

If yes, the address of your home: _____



Money Follows the Person (MFP) Transition Screening Form



Participant Name: _____

19. If applicable, does anyone live in your home? Yes No

What are their names and relationship to you? _____

(Screener note: introduce MFP qualified housing options. Tell the candidate that while MFP will assist the person to locate qualified housing, the MFP program does not cover the cost of rent or utilities and that to participate in MFP, the person must enter one of three types of qualified housing--

- A home owned or leased by the individual or the individual’s family member,
- An apartment with an individual lease, with lockable entry door, that includes living, sleeping and bathing and cooking areas over which the individual or the individual’s family have domain and control, or
- A residence, in a community based residential setting, in which no more than 4 unrelated individuals reside)

20. Which type of qualified housing are you interested in and why? _____

21. Do you have someone you want to live with? Yes No

If yes, list contact information _____

22. Did you receive services in your home before coming to (name of facility)?

Yes No If yes, what service(s): _____

23. Are you currently on a waiver waiting list for home & community based services?

Yes No If so, which waiver? _____

24. Do you have a letter or contact information from the waiver? Yes No

If yes, where is the letter or contact information and/or who can bring these to

you? _____

(Screener note: contact the waiver program manger for this information).



Money Follows the Person (MFP) Transition Screening Form



Participant Name: _____

Financial Data:

(Screener note: Review facility records to obtain or confirm this information. The signed informed consent should allow you to obtain these records).

25. Income and Resources:

SOURCE	MONTHLY AMOUNT	PAYEE
<input type="checkbox"/> SSDI <input type="checkbox"/> SSI		
SOCIAL SECURITY Retirement		
TRUST PROCEEDS		
INHERITANCE		
VETERAN'S COMPENSATION		
CASH		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
SAVINGS ACCOUNT (DESIGNATED BURIAL)		
CEMETERY PLOT		
PENSION BENEFITS		
RAILROAD RETIREMENT		
LIFE INSURANCE		
CERTIFICATE OF DEPOSIT		
OTHER (SPECIFY)		
OTHER (SPECIFY)		
OTHER (SPECIFY)		



Money Follows the Person (MFP) Transition Screening Form



Participant Name: _____

26. Who is paying for your stay here at (this facility)? _____

27. Are you Medicaid eligible, but subject to transfer of asset penalty?
 Yes No Don't Know (Screener note: check facility records)

Health Care Needs:

28. Diagnoses (include Self-Reported Diagnoses): _____

29. Who is your doctor here at (name of facility)? _____

30. Do you have a primary care doctor in the community? Yes No

If yes, what is her/his name and contact information? _____

31. Do you need help taking your daily medications? Yes No

Describe assistance needed: _____

32. What specialized medical equipment (DME) and assistive technology devices do you use?

33. Which equipment or devices need to be obtained because you don't own them or they need to be replaced?



Money Follows the Person (MFP) Transition Screening Form



Participant Name: _____

34. Functional Needs:

Function	Impairment	Unmet Need for Care	Case Comments: Identify resources, assistive technology, DME used. Describe special needs and circumstances that should be taken into account when developing a plan for services and supports
1. Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Grooming	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Transferring	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Contenance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Managing Money	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Telephoning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Preparing Meals	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Housework	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Outside Home	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Routine Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Special Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Being Alone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
KEY			
Assistance Needed in the Community		Unmet Need for Care – when person returns to the community	
Ask: Do you need help with _____ (activities listed above #1-15)? When appropriate, observe the person in the activity.		Ask: When you return to the community, do you have someone to help you with _____ (activities listed above #1-15)? If participant has assistance of family/friend/caregiver or assistive device, the answer would be NO . If participant has no assistance, the answer would be YES (there is an unmet need for care) . Note observations in case comments.	

(Screener note: To qualify for MFP, the person must have at least one unmet need).



Money Follows the Person (MFP) Transition Screening Form



Participant Name: _____

35. Home Community Based Service (HCBS) referral to:
- CCSP (AAA/Gateway)
 - SOURCE (SOURCE Case Management)
 - Independent Care Waiver (ICWP) (GMCF)
 - New Options Waiver (NOW) (Regional DBHDD Office)
 - COMP Waiver (Regional DBHDD Office)
 - State Plan Services (list) _____
 - Non Medicaid HCBS (specify) _____

36. Date of referral to waiver _____ (mm/dd/yyyy).

37. Date HCBS application submitted: _____ (mm/dd/yyyy)

38. Date HCBS waiver assessment completed: _____ (mm/dd/yyyy)

39. Person Refused Program Yes No
 (Screener note: if the person decides to discontinue the interview at any time, ask the person/guardian why they decided not to continue and list reason(s) below)

Document Checklist:

(Screener note: attach the following documents. Send these copies and copy of completed Screening Form with referral to AAA/Gateway and/or GMCF).

- Copy of *MFP Consent for Participation*
- Copy of *Authorization for Use or Disclosure of Health Information*
- Copy of Medication Administration Record (MAR) or list of current medications
- Copy of State Medicaid Card
- Copy of Medicare Card
- Copy of Social Security Card
- Copy of Legal documents that cover guardianship (on file at institution)
- Copy of Documents that cover Power of Attorney (on file at institution)
- Nursing Home Facesheet
- Other (Specify) _____
- Other (Specify) _____

Notes: _____

Transition Coordinator Name: _____ Date: _____

Transition Coordinator Phone: _____ Email: _____

APPENDIX H



MFP Recruiting Text

Rev_08/11/2010

Georgia Money Follows the Person helps people living in nursing facilities and Intermediate Care Facilities (ICFs) to transition and resettle into qualified residences in the community. If you have lived in a nursing facility or ICF for at least 90 days (with some exceptions), you may qualify for the MFP program. If you are interested and want more information on Money Follows the Person, you can contact:

- The Georgia Department of Community Health Money Follows the Person project, at 404-657-9323
- The Department of Human Services, Division of Aging Services at 1-866-55-AGING (1-866-552-4464),
- The Office of the Long Term Care Ombudsman at 1-888-454-5826, or
- Aging and Disability Resource Connections at 800-676-2433.

MFP offers transition services to qualified Medicaid eligible older adults, adults and children with physical disabilities, acquired brain injury, and developmental disabilities.

MFP uses home and community-based Medicaid waiver services and 'one-time' transition services to help people to resettle in an apartment or home or a group home with four or fewer unrelated adults. After receiving 365 days of MFP services, MFP participants will continue receiving services through the Medicaid Home and Community Based Waiver Services (HCBS), Medicaid State Plan services, non-Medicaid federal funds such as the Social Services Block Grant and the Older Americans Act, state funded programs, and local community support systems and funding beyond the MFP demonstration period.

MFP participants may qualify for the following transition services to assist them:

- Peer Community Supports
- Household Furnishings
- Household Goods and Supplies
- Moving Expenses
- Utility Deposits
- Security/Rent Deposits
- Transition Services
- Transportation
- Skilled Out-of-Home Respite
- Caregivers Training
- Long Term Care Ombudsman Services

- Equipment and Supplies
- Vehicle Adaptations
- Environmental Modifications for Accessibility

At this time, persons eligible for MFP will not be referred to a waiver program waiting list. MFP participants will enter a waiver immediately upon discharge from the institution. Waiver services will continue to transitioned individuals beyond the 365 day MFP demonstration period. Transitioned individuals enter an appropriate waiver program and receive waiver services as long as they meet the institutional level of care criteria for these services.

Appendix I **SOURCE Providers**

Revised 7/31/2009

Albany ARC

Contact Person: Grace Williams or Sahirah Hall (229) 883-2334

Fax: (229) 431-8534

1319 W Broad Street, Albany, GA 31707

Counties: Baker, Calhoun, Clay, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell Thomas, Worth

Columbus Regional Healthcare System

Contact Person: Jenny Dowdy (706) 660-6356

Fax: (706) 660-6279

1900 10th Avenue, Columbus GA, 31901

Counties: Chattahoochee, Harris, Marion, Muscogee, Talbot

Crisp Regional Health Services, Inc. d/b/a

Crisp Care Management

Contact Person: Alicia McInvale, RN (229) 273-6282

Fax: 229-273-5990

910 North 5th Street, Cordele, GA 31015

Counties: Crisp, Dooley, Macon, Pulaski, Sumter, Wilcox

Diversified Resources Inc.

Contact Person: Owner/Administrators: Pat Albritton or Kathy Yarbrough (912) 285-3089 or 1800-283-0041

Case Manager Supervisor: Donna Robinson, RN, BSN

Fax: (912) 285-0367

147 Knight Avenue Circle

P. O. Box 1099 (31502)

Waycross, Georgia 31503

Counties: Atkinson, Clinch, Coffee, Pierce and Ware

Nahunta Office

Contact Person: Vickie Chesser, RN, CM Supervisor (912) 462-8449 or (866) 903-7473

179-A North Main Street, Nahunta, GA 31553

Counties: Brantley, Camden, Charlton, Glynn

Tifton Office

Contact Person: Robin Harris, RN, CM Supervisor (229) 386-9296 or (800) 575-7004

1411 US Highway 41 North

P.O. Box 7614

Tifton, Georgia 31793

Counties: Ben Hill, Irwin, Tift, Turner, Wilcox

Valdosta Office

Contact Person: Donna Robinson, Acting CM Supervisor (229)253-9995 or (800) 706-9674

124 N. Patterson St.

Valdosta, Ga. 31602

Counties: Berrien, Brooks, Cook, Echols, Lanier and Lowndes

Faith Health Services

Contact: Faith Vickerie- Morgan, RN (678) 624-1646

Fax: 770-442-3320

P.O. Box 2063, Alpharetta, GA 30023

Counties: Fulton, Cobb, Clayton, Dekalb, Forsyth, Gwinnett, Rockdale

Wesley Woods (Atlanta SOURCE)

Contact Person: Teresa Thompson or Sherry Watts (404) 728- 6555

Fax: (404) 728-4973

52 Executive Park South, N.E., Suite 5200, Atlanta, GA 30329

Counties: Dekalb, Fulton

Source Care Management LLC

108 South Broad Street

Butler, Georgia 31006

Contact Person: Caroline McDaniel, RN, BSN, Executive Director (478) 621-2070 ext. 2871

Kimberly Thomas, RN, BSN, Assistant Executive Director (478) 621-2070 ext. 2872

Lou Ann Moulton (478) 621-2070 ext. 2861

Fax: (478) 862-9111

Alt Number: (888)-762-2420

E-mail: info@source-ga.org

SCM OFFICES

Americus

CMS: Deanna Campbell

Ph: 478-621-2070 Extension 2981

Fax: 229-928-4485

121 Habitat Street, Bldg. D, Americus, GA 31709

Counties: Crisp, Dodge, Dooly, Lee, Pulaski, Sumter, Terrell, Turner, Wilcox, Worth

Augusta

CMS: Jan Parsons

Ph: 478-621-2070 ext 2731

Fax: 706-737-0205

2531 Center West Parkway, Suite 130, Augusta 30909

Counties: Burke, Columbia, Lincoln, McDuffie, Richmond, Taliaferro, Warren

Athens

CMS: Steven Johnston

Ph: 478-621-2070ext 2882

Fax: 706-543-8293

1865 West Broad St. Suite B, Athens, GA 30606

Counties: Banks, Barrow, Clark, Elbert, Franklin, Greene, Hart, Jackson, Madison, Morgan, Oconee, Oglethorpe, Stephens, Wilkes

Butler

CMS: Claire Locke

Ph: 478-621-2070 Ext 2832

Fax: 478-862-4844

12 South Broad Street, Butler, GA 31006

Counties: Macon, Marion, Schley, Talbot, Taylor, Upson

Columbus

CMS: Richard Morgan, LPN, BS, MS

Ph: (478) 621-2070 Extension 2861

Fax: 706-562-2342

3575 Macon Rd. Suite 18, Columbus, GA 31907

Counties: Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, Stewart, Webster

Douglas

CMS: Sheri Boulet, RN

Ph: (478) 621-2070 Ext 2627

Fax: (912) 592-4630

114 North Peterson Avenue, Suite 205, Douglas, GA 31533

Counties: Atkinson, Bacon, Ben Hill, Berrien, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Tift, Ware

Duluth

CMS: Dot Rodriguez, LPN

Ph: (478) 621-2070 Ext 2651

Fax: (770) 717-2692

2825 Breckenridge Blvd., Suite 130, Duluth, GA 30096

Counties: Dawson, DeKalb, Fannin, Forsyth, Gwinnett, Habersham, Hall, Lumpkin, Newton, Rabun, Rockdale, Towns, Union, Walton, White

Eatonton

CMS: Keith Estes, BA, MS, Administrator

951 Harmony Rd., Suite 104

Eatonton, Georgia 31024

Counties: Baldwin, Greene, Hancock, Jasper, Lincoln, McDuffie, Morgan, Putnam, Taliaferro, Warren, Wilkes

Jesup

CMS: Brittany Matthews, RN, BSN

Ph: (478) 621-2070 Ext

Fax: 912-427-2672

248 NE Broad Street, Jesup, GA 31546

Counties: Appling, Brantley, Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh, Pierce, Wayne

Macon

Temporary CMS: Ronni Peyatt

Ph: 478-621-2070 Ext 2777

Fax: 478-471-0751

1760 Bass Road, Suite 203, Macon, GA 31210

Counties: Bibb, Bleckley, Butts, Crawford, Houston, Jasper, Jones, Lamar, Monroe, Peach, Putnam, Twiggs

Metter

CMS: Linda Reigo, LPN

Ph: (478) 621-2070 Ext 2601

Fax: (912) 685-7640

58 SE Broad Street, Metter, GA 30439

Counties: Bulloch, Candler, Emanuel, Evans, Jeff Davis, Jenkins, Montgomery, Screven, Tattnall, Telfair, Toombs, Treutlen, Wheeler

Newnan

CMS: Lucinda Melson, BS, MA

Ph: 478-621-2070 Ext 2812

Fax: 770-304-9521

772 Greison Trail, Suites H & I, Newnan, GA 30263

Counties: Carroll, Clayton, Coweta, Douglas, Fayette, Fulton, Heard, Henry, Meriwether, Pike, Spalding, Troup

Rome

CMS: Scarlet Freelin, BS

Ph: 478-621-2070 Ext 2757

Fax: 706-378-1330

701 Broad Street, Suite 201, Rome, GA 30161

Counties: Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield

Thomasville

CMS: Terri Brinson, RN

Ph: (478) 621-2070 Ext 2902

Fax: (229) 227-6157

14004 Hwy. 19 S. Suite 101 & 102, Thomasville, GA 31757

Counties: Baker, Brooks, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Miller, Mitchell, Seminole, Thomas,

Wrightsville

CMS: Sharon Jones
Ph.: (478) 621-2070 Ext 2926
Fax : (478) 864-9423
112 S. Marcus Street, Wrightsville, GA 31906
Counties: Baldwin, Glascock, Hancock, Jefferson, Johnson, Laurens, Washington, Wilkinson

Legacy Link, Inc.

Contact Person: Pat Freeman or Dianne Curran (770) 538-2650
Fax: (770) 538-2660
508 Oak Street, Suite 1, Gainesville, GA 30503
Counties: Banks, Barrow, Cherokee, Clark, Dawson, Elbert, Forsyth, Franklin, Gwinnett, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Rabun, , Stephens, Towns, Union, White

St. Joseph's/Candler Health System

Contact Person: Susan Earl or Betsy Boykin or Jackie Immel (912) 819-1520 or (866) 218-2259
Fax (912) 819-1548
1900 Abercorn Street, Savannah, GA 31401
Counties: Bryan, Bulloch, Candler, Chatham, Effingham, Evans

Baxley Office

Contact Person: Jilda Brown or Tonya Strickland (866) 835-0709 or (912) 367-6108
Fax (912) 367-0392
338 East Parker Street, Baxley, GA 31513
Counties: Appling, Bacon, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Tattnall, Toombs, Wayne

UniHealth Solutions SOURCE-Corporate Office

Juliette Simpson (770) 925-4788
1626 Jeurgens Court. Norcross, GA 30093

UniHealth Solutions Athens

Contact Person: Melissa Wilson, RN, BSN, CM Supervisor (706) 549-3315
Fax: (706) 543-3841
435 Hawthorne Ave., Suite 300, Athens, GA 30606
Counties: Banks, Barrow, Clark, Elbert, Franklin, Greene, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Stephens, Walton

UniHealth Solutions Atlanta

Contact Person: Peggy Stoneking Office Manager (678) 533-6200
Fax: (678) 533-6488
1626 Jeurgens Court. Norcross, GA 30093
Counties: Clayton, Dekalb, Fulton, Forsyth, Gwinnett, Hall, Henry, Newton, Rockdale, Spalding

UniHealth Solutions Augusta

Contact Person: Daphne M. Jean, RN, BSN, CM Supervisor (706) 651-1535

Fax: (706) 863-9401

620 Ponder Place, Evans, GA 30809

Counties: Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

UniHealth Solutions North Georgia Mountain/Blueridge

Contact Person: Carol Roberson, CM Supervisor (706) 258-5300

Fax (706) 632-0028

5004 Appalachian Hwy, Suite 4, Blueridge, GA 30513

Counties: Cherokee, Dawson, Fannin, Gilmer, Lumpkin, Pickens, Rabun, Towns, White

UniHealth Solutions Cobb

Contact Person: Karen Bowden, RN, BSN, CM Supervisor (770) 916-4502

Fax: (770) 916-4505

1640 Powers Ferry Road, Bldg. 3, Suite 100, Marietta, GA 30067

Counties: Carroll, Cobb, Douglas, Paulding

UniHealth Solutions Columbus

Contact Person: Sheila Warren, RN, Regional Director (706) 322-7713

Fax: 706-322-7716

1133 13th Street, Columbus, GA 31901

Counties: Chattahoochee, Marion, Muscogee, Quitman, Stewart, Webster

UniHealth Solutions Cordele

Contact Person: Sherry Smith, RN, CM Supervisor (229) 273-2570

708 E, 16th Avenue, Cordele, GA 31015

Fax: (229) 273-4750

Counties: Ben Hill, Bleckley, Clay, Crisp, Dodge, Dooly, Dougherty, Irwin, Lee, Macon, Marion, Pulaski, Randolph, Schley, Sumter, Telfair, Tift, Turner, Wilcox, Worth

UniHealth Solutions Jesup

Contact Person: Sherry Smith, RN, CM Supervisor (912) 530 7359

Fax: (912) 530-7362

151 East Cherry Street, Jesup, GA 31546

Counties: Appling, Bacon, Brantley, Camden, Charleton, Glynn, Peirce, Wayne

UniHealth Solutions Macon

Contact Person: Rita B. Davis RN, CM Supervisor (478) 474-0979 or (800) 913-0134

Fax: (478) 474-2068

6060 Lakeside Commons Drive, Box 9, Macon, GA 31210

Counties: Baldwin, Bibb, Butts, Crawford, Houston, Jasper, Jones, Lamar, Laurens, Monroe, Peach, Pike, Putnam, Taylor, Twiggs, Upson, Wilkinson

UniHealth Solutions Newnan

Contact Person: Sheila Warren (770) 254-1545

Fax: (770) 254-8605

770 Greison Trail, Suite B, Newnan, Georgia 30263

Counties: Coweta, Fayette, Fulton (Zip Code 30291), Harris, Heard, Meriwether, Pike, Spaulding, Talbot, Troup

UniHealth Solutions Savannah

Contact Person: Nathalie Douglas, RN, CM Supervisor (912) 925- 9181

Fax: 912-925-9340

9100 White Bluff Road, Suite 303, Savannah, GA 31406

Counties: Bryan, Chatham, Effingham, Liberty, Long, McIntosh

UniHealth Solutions Rome

Contact Person: Nancy Green, CM Supervisor (706) 236- 4705

Fax: 706-232-5912

39 Three Rivers Drive, NE, Rome, GA 30161

Counties: Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haralson Murray, Polk, Walker, Whitfield

UniHealth Solutions of Swainsboro

Contact Person: Robin Sherrod, RN - CM Supervisor (478) 237- 7270

Fax (770-237-7290

667 South Main Street, Swainsboro, GA 30401

Counties: Bulloch, Chandler, Emmanuel, Evans, Johnson, Montgomery, Tattnall, Tombs, Treutlen, and Wheeler

UniHealth Solutions Valdosta

Contact Person: Fay Baker, RN, CM Supervisor, (229) 241-8750

Fax: 229-241-8940

407 Cowart Ave, Valdosta, Georgia 31602

Counties: Atkinson, Berrien, Brooks, Clinch, Coffee, Colquitt, Cook, Echols, Jeff Davis, Lanier, Lowndes, Thomas, Ware

Georgia Corner of Care

Contact Person: Juanita Benjamin (706) 496-3901

Fax: (706) 496-3890

1105 Druid Park Avenue, Augusta, GA 30904

County: Richmond

SOURCE Partners Atlanta

Contact Person: Karen Bear (404) 463-3248

Fax: (404) 463-3264

40 Courtland Street, NE, Atlanta, GA 30303

Counties: Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale



APPENDIX J CHECKLIST FOR TRANSFER TO COMMUNITY PLACEMENT

For Community Care Services Program (CCSP) and Independent Care Waiver Program (ICWP)
Rev_081110



Participant Name: _____ **MHN/SS#:** _____

Discharged From: _____ **DOB:** _____

Step	Responsible Person	Action Step	Results
1. Participant is identified as eligible for screening.	<ul style="list-style-type: none"> • Facility • Transition Coordinator 		
2. Ensure that each participant has expressed a desire to leave the institution.	<ul style="list-style-type: none"> • Participant • Transition Coordinator 		
3. Initial face-to-face screening form is complete and participant is MFP-eligible .	<ul style="list-style-type: none"> • Participant • Transition Coordinator 		
4. All applicable consent and release forms obtained and signed. <ul style="list-style-type: none"> • <i>MFP Consent For Participation</i> • <i>Authorization for Use or Disclosure of Health Information</i> Verification of guardianship obtained if applicable.	<ul style="list-style-type: none"> • Participant • Transition Coordinator 		

Step	Responsible Person	Action Step	Results
5. Provide participant with copies of the <i>Home and Community Services: A Guide to Medicaid Waiver Programs in Georgia</i> , and a copy of the <i>Participant Transition Planning Guide</i> .	<ul style="list-style-type: none"> • Participant • Participant Rep/Guardian • Transition coordinator 		
6. If referred to a waiver, <i>MFP Transition Screening Form</i> and attachments are complete to determine waiver eligibility / appropriateness and then sent to assigned waiver program for pre-screen.	<ul style="list-style-type: none"> • Transition Coordinator 		
7. The participant accepts waiver recommendation.	<ul style="list-style-type: none"> • Participant • Transition Coordinator 		
8. Establish and convene the transition team (includes the participant's circle-of-support/friends) with the participant to review service needs and complete person-directed planning. Together, the team should determine individualized support needs, including living arrangements and medical supports where applicable.	<ul style="list-style-type: none"> • Participant • Transition Coordinator 		

Step	Responsible Person	Action Step	Results
9. The support network assists the participant/family in choosing and verifying services from a list of MFP transitional services and providers, if applicable.	<ul style="list-style-type: none"> • Participant • Transition Coordinator • Waiver CC 		
10. Once determined eligible for a waiver, continue person-directed planning meetings with participant, family/friends and support/transition team to develop <i>Individualized Transition Plan (ITP)</i> Parts A MFP Services, and Part B for waiver services and Part C State Plan Services (if applicable).	<ul style="list-style-type: none"> • Participant • Transition Coordinator • Waiver CC 		
11. When necessary, arrange pre-transition visit of participant to community setting.	<ul style="list-style-type: none"> • Transition Coordinator • Waiver CC • Participant 		
12. Process <i>MFP Authorization for Transition Services</i> . Arrange for vendors to provide pre-transition services. *Note: Will appear as needed throughout the billing process	<ul style="list-style-type: none"> • Transition Coordinator • Vendor • DCH/LTC 		

Step	Responsible Person	Action Step	Results
<p>13. Initiate pre-transition services. Vendors submit <i>Request for Vendor Payment</i> along with documentation of delivery of goods/services to Transition Coordinator (TC). TC must submit <i>Vendor Import File</i> monthly to the Fiscal Intermediary (FI) and long term care office with all documentation.</p> <p>*Note: Will appear as needed throughout the billing process</p>	<ul style="list-style-type: none"> • Transition Coordinator 		
<p>14. <i>Quality of Life</i> (QOL) survey completed 30 days to two weeks prior to discharge.</p>	<ul style="list-style-type: none"> • Transition Coordinator • Participant 		
<p>15. Date established for participant discharge from institution.</p>	<ul style="list-style-type: none"> • Participant • Transition Coordinator • Waiver CM 		
<p>16. When discharge date established:</p> <p style="padding-left: 20px;">A) Terminate institution enrollment and change Medicaid eligibility.</p> <p style="padding-left: 20px;">B) Reverse social security benefits</p>	<ul style="list-style-type: none"> • Participant • TC • DCH/LTC • DFCS 		

Step	Responsible Person	Action Step	Results
17. <i>Discharge Day Checklist</i> is complete.	<ul style="list-style-type: none"> • Transition Coordinator 		
18. TC contacts participant services and Long Term Care/ Money Follows the Person (LTC/MFP) office via e-mail or fax with information for data entry into manual tracking system.	<ul style="list-style-type: none"> • Transition Coordinator • DFCS 		
19. Participant is locked into MFP and enters waiver.	<ul style="list-style-type: none"> • MMIS 		
20. Waiver services begin.	<ul style="list-style-type: none"> • MMIS • Participant • Waiver CC • Waiver Service Providers • Transition Coordinator 		
21. Coordinate and/or arrange for the 2 nd Quality of Life (QoL) survey to be completed between 11 and 12 months post-discharge (resettlement).	<ul style="list-style-type: none"> • Transition Coordinator • QoL Surveyor • Participant 		

Notes:

APPENDIX L
Aging and Disability Resource Connection List
 Revised 52110

<i>Planning & Service Area</i>	<i>ADRC Name, Address & Phone</i>
Atlanta Region Cherokee Clayton Cobb DeKalb Douglas Fayette Fulton Gwinnett Henry Rockdale	Atlanta Regional Commission 40 Courtland Street, N.E. Atlanta, GA 30303-2538 Phone: 404-463-3333 Toll Free: 800-676-2433 Website: www.agewiseconnection.com
Central Savannah River Area Burke Richmond Columbia Screven Glascock Taliaferro Hancock Warren Jefferson Washington Jenkins Wilkes Lincoln McDuffie	Central Savannah ADRC 3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 Phone: 706-210-2018 Toll Free: 888-922-4464 Website: www.csrardc.org
Coastal Area Bryan Bulloch Camden Chatham Effingham Glynn Liberty Long McIntosh	Coastal ADRC 127 F Street Brunswick, GA 31520 Phone: 912-262-2862 Toll Free: 800-580-6860 Website: www.coastalgeorgiardc.org
River Valley Chattahoochee Quitman Clay Randolph Crisp Schley Dooley Stewart	River Valley ADRC 1428 Second Avenue PO Box 1908 Columbus, GA 31902-1908 Phone: 706-256-2900 Toll Free: 800-615-4379 Website: www.lcrdcaaa.org

<i>Planning & Service Area</i>	<i>ADRC Name, Address & Phone</i>
Harris Sumter Macon Talbot Marion Taylor Muscogee Webster	
Northeast Georgia Barrow Newton Clarke Oconee Elbert Oglethorpe Greene Walton Jackson Jasper Madison Morgan	Northeast Georgia ADRC 305 Research Drive Athens, GA 30610 Phone: 706-583-2546 Toll free: 800-474-7540 Website: www.negrdc.org
Northwest Georgia Bartow Murray Catoosa Paulding Chattooga Pickens Dade Polk Fannin Walker Floyd Whitfield Gilmer Gordon Haralson	Northwest Georgia ADRC Physical Address: 1 Jackson Hill Dr. Rome, GA 30161 Mailing Address: PO Box 1798 Rome, GA 30162-1798 Phone: 706-802-5506 Toll Free: 888-759-2963 Website: www.northwestga-aaa.org
Southern Georgia Atkinson Cook Bacon Echols Ben Hill Irwin Berrien Lanier Brantley	Southern Georgia ADRC 1725 South Georgia Parkway, West Waycross, GA 31503-8958 Phone: 912-287-5888 Toll Free: 888-732-4464 Website: www.segardc.org

<i>Planning & Service Area</i>	<i>ADRC Name, Address & Phone</i>
Lowndes Brooks Pierce Charlton Tift Clinch Turner Coffee Ware	
Southwest Georgia Baker Lee Calhoun Miller Colquitt Mitchell Decatur Seminole Dougherty Terrell Early Thomas Grady Worth	SOWEGA ADRC 1105 Palmyra Road Albany, GA 31701-1933 Phone: 229-432-0994 Toll free: 800-282-1026 Website: www.sowegacoa.org
Southern Crescent Butts Pike Carroll Spalding Coweta Troup Heard Upson Lamar Meriwether	Southern Crescent ADRC Physical Address: 13273 Hwy. 34 East Franklin, GA 30217 Mailing Address: PO Box 1600 Franklin, GA 30217-1600 Phone: 706-407-0033 Toll Free: 866-854-5252 Website: www.scaaa.net

APPENDIX N

Non-Emergency Transportation Broker System

The Medicaid Non-Emergency Transportation (NET) program provides transportation through a NET Broker system. Five NET regions have been established in the State—North, Atlanta, Central, East and Southwest. The Department has contracted with a Broker in each of the five NET regions to administer and provide non-emergency transportation for eligible Medicaid members. The Brokers are reimbursed a monthly capitation rate for each Medicaid member residing within their region.

Medicaid members who need access to medical care or services covered by Medicaid and have no other means of transportation must contact the Broker servicing their county to arrange for appropriate transportation. Non-emergency transportation is provided only in the absence of other transportation. Each Broker is required to maintain toll free telephone access for transportation scheduling services Monday thru Friday from 7:00 a.m. to 6:00 p.m.

Effective January 1, 2007, contracts for the Non-Emergency Transportation Services Broker program were awarded to LogistiCare, Inc., Southeastrans, Inc., and Southwest Georgia Regional Development Center. The contact information and coverage area, for each broker, are listed in the table below:

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Gwinnett, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee, Paulding, Pickens, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White, Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb
Central	Southeastrans Toll free 1-866-991-6701 Local 404-305-3535	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox, Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne, Wilkes
Southwest	Southwest Georgia Regional Development Center Toll free 1-866-443-0761	Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster, Worth

APPENDIX P

Appendix P: Startup Household Goods and Supplies Worksheet

ITEMS	OWNS/FAMILY	DOLLAR GENERAL	WALMART	DOLLAR TREE	BIG LOTS	TARGET
Kitchen						
Dishes						
Silverware						
Kitchen Knives						
Glasses						
Cups						
Tea Pitcher						
Tupperware						
Pots/Pans						
Cookie Sheet						
Cooking Utensils						
Can Opener						
Measuring Cups						
Salt/Pepper Shakers						
Pot Holders/Mitt						
Kitchen Trash Can						
Kitchen Towels						
Dish Cloths						
Dish Drainer						
Ice Trays						
Cleaning						
Paper Towels						
Laundry Detergent						
Round Laundry Basket						
Bleach						
All Purpose Cleaner						
Pine Cleaner						
Glass Cleaner						
Dish Liquid						
Glade Spray						
Lysol						
Broom						
Mop						
Mop Bucket						
Dust Pan						

MFP_Household_Goods_Supplies_Revised_091109

Appendix P: Startup Household Goods and Supplies Worksheet

ITEMS	OWNS/FAMILY	DOLLAR GENERAL	WALMART	DOLLAR TREE	BIG LOTS	TARGET
Dust Cloths						
Toilet Brush						
Trash Bags						
Light Bulbs						
Bedroom						
Blanket						
Sheet Set						
Pillow						
Alarm Clock						
Toilet Tissue						
Tissues						
Bathroom						
Bath Towels						
Hand Towels						
Wash Cloths						
Shower Curtain						
Shower Hooks						
Small Trash Can						
Toiletries						
Shampoo						
Soap						
Lotion						
Toothpaste						
Mouthwash						
Razors						
Hand Soap (Pump)						
Other						
Speaker Phone/big #						
Coasters						

Grand Total: All Stores
(Cheapest Prices)

MFP_Household_Goods_Supplies_Revised_091109

APPENDIX Q1



INDIVIDUALIZED TRANSITION PLAN (ITP)



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Participant Name: _____

1. MFP PARTICIPANT INFORMATION

Participant First Name: _____ Last Name: _____

Medicaid # _____ Medicare # _____

First Name: _____ MI: __ Last Name: _____

Date of Birth: _____

Facility Name: _____

Facility Location: _____

Individualized Transition Plan (ITP) date: _____

This ITP is an Initial ITP -OR- Updated ITP (check only one).

Projected move to: _____
(Type of living arrangement – apt, home, 4 person home etc.)

Prepared by: _____
(TC Name and Contact information)

2. IMPORTANT PLANNING DATES

Projected Discharge/Move out Date: _____

Actual Discharge/ Move out Date: _____

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Participant Name: _____

3. HOUSING CHOICE/LIVING ARRANGEMENTS:

Indicate housing choice priority (1, 2, 3 etc) and describe tasks that must be done to secure choice:

_____ OWN HOME- _____

_____ WITH FAMILY/FRIENDS- _____

_____ RENTAL UNIT- _____

_____ QUALIFIED GROUP HOME- _____

(Continue narrative on back or add additional pages as needed)

4. HOUSING ISSUES, BARRIERS AND STRATEGIES FOR BARRIER REMOVAL (describe in detail):

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Participant Name: _____

5. PERSONAL GOALS/ DESIRED OUTCOMES (describe in detail):

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

6. HEALTH AND NUTRITION GOALS (describe in detail):

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)

Participant Name: _____



7. 24/7 EMERGENCY BACKUP PLANS (describe in detail):

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

8. VISION/HEARING/MOBILITY GOALS (describe or indicate N/A):

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

9. **COMMUNICATION GOALS** (describe or indicate N/A

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

10. **AFFECTIVE/SOCIAL/RECREATIONAL GOALS** (describe or indicate N/A

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)

DCH/MFP Individualized Transition Plan (ITP) 020609

Page 5 of 14



INDIVIDUALIZED TRANSITION PLAN (ITP)



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Participant Name: _____

11. SELF-CARE (DOMESTIC/ PERSONAL) GOALS (describe or indicate N/A):

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

12. ADAPTIVE EQUIPMENT USE AND NEEDS (describe or indicate N/A) :

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Participant Name: _____

13. BARRIERS & FACILITATORS TO COMMUNITY ACCESS (describe):

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO REMOVE BARRIERS:

14. VOCATIONAL GOALS (describe or indicate N/A):

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

15. TRANSPORTATION NEEDS AND BARRIERS (describe or indicate N/A)

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO REMOVE BARRIERS:

16. FINANCIAL GOALS: (describe or indicate N/A) (see also #22 Income & Resources-Budget for Community Living)

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ACHIEVE GOALS:

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

17. LEGAL ISSUES (describe or indicate N/A):

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO ADDRESS ISSUES:

18. FRIENDS/FAMILY/GUARDIAN INVOLVEMENT ISSUES (describe or indicate N/A)

RESOURCES (PERSONAL, MFP/WAIVER, COMMUNITY SERVICES) TO RESOLVE ISSUES

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

19. PART A: MFP PRE AND POST-TRANSITION SERVICES

Use the table below to list the MFP Pre-and Post-Transition Services selected by the member/team along with the justification for each. The MFP member initials each choice.

MFP PRE-TRANSITION SERVICE	RATIONALE (provide justification for why this MFP service is needed to support successful living in the community)	MFP MEMBER INITIAL

MFP POST-TRANSITION SERVICE	RATIONALE (provide justification for why this MFP service is needed to support successful living in the community)	MFP MEMBER INITIAL

Note to TCs: Send this completed ITP to the DCH/MFP Office via File Transfer Protocol (FTP) or by fax.

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

20. TRANSITION PLAN ASSIGNMENTS:

Assignment	Person Responsible	Projected Date of Completion	Actual Date of Completion

Prompts:

- Housing Search
- Medicaid eligibility
- Quality of Life Survey
- Independent Living and/or Personal Services and Supports Training Issues
- Household Goods and Furnishings
- Transition visits from Ombudsman
- Other characteristics/preferences
- Transportation
- Medical/Dental/Medications
- Specialized equipment and assistive technology
- Counseling

(Continue narrative on back or add additional pages as needed)



INDIVIDUALIZED TRANSITION PLAN (ITP)

Participant Name: _____



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

21. FOLLOW UP PLANS:

22. INCOME AND RESOURCES-Budget for Community Living:

(Continue narrative on back or add additional pages as needed)

DCH/MFP Individualized Transition Plan (ITP) 020609

Page 12 of 14



INDIVIDUALIZED TRANSITION PLAN (ITP)



Participant Name: _____

23. PART B: WAIVER SERVICES:

Use the table below to list the Waiver Services selected by the member and the waiver case manager/care coordinator. The MFP member initials each choice.

WAIVER SERVICE (i.e., personal support)	RATIONALE (describe how service will work with MFP services to support member in the community)	MEMBER INITIAL

24. PART C: STATE PLAN SERVICES (identify or indicate N/A):

Use the table below to list additional services selected by the member/team. The MFP member initials each choice.

OTHER SERVICE	RATIONALE (describe how service will work with MFP services to support member in the community)	MEMBER INITIAL

Note to TCs: Send this completed ITP to the DCH/MFP Office via File Transfer Protocol (FTP) or by fax.

(Continue narrative on back or add additional pages as needed)

APPENDIX Q2
GUIDELINES FOR COMPLETING THE
INDIVIDUALIZED TRANSITION PLAN (ITP)

Rev_020909

- AN INDIVIDUALIZED TRANSITION PLAN (ITP) will be completed prior to all moves associated with transitions from nursing facility/institutional settings to community settings.
- The ITP must be completed at the time a MFP participant is selected for resettlement. Person-centered planning will be undertaken to complete the ITP. Person-centered planning meetings will include the MFP participant, family members, friends, care givers, guardian (if applicable), the Transition Coordinator, the nursing facility/institutional discharge planner, and/or waiver case manager and other appropriate facility staff.
- The MFP Transition Coordinator will be responsible for facilitating the development and writing of the ITP, including the documentation in the plan and monitoring the outcomes. A complete ITP includes the participant's goals/desired outcomes, choices of living arrangements, preferences, strengths, barriers to transition, MFP Service needs in Part A, Waiver Service needs in Part B and State Plan Services in Part C.
- The Transition Coordinator will distribute a copy of the ITP showing specific transition assignments to all persons having an assignment to complete. The ITP will be distributed prior to discharge to assure timely implementation.
- The MFP participant, friends, family members and appropriate transition planning members should receive a copy of the ITP.
- The Department of Community Health (DCH), Office of Long Term Care must receive a copy of the completed ITP.
- The team will review the ITP two to four weeks before the discharge date from the nursing facility/institution, more often if needed and will be updated with any changes in status. Updates to the ITP will be documented.

Guidelines and examples for completing the ITP:

1. Enter the requested participant information. Enter the requested facility name and location. Enter the date the ITP was prepared. Check the appropriate box for the stage of the ITP (initial or updated). Enter the type of living arrangement the participant is expected to enter. Enter the Transition Coordinator name and contact information.
2. Enter the projected discharge/move out date and actual discharge/move out date.
3. Housing Choice/Living Arrangement: Include choices of living arrangements, community setting (qualified community housing community-based; quieter environment; closer to friends and family; opportunity for greater independence

in activities of daily living; family setting; person/friends/family supports the move.

4. Issues/Concerns: The MFP participant may have lived for several months or years at the facility and may need assistance with independent living skills, budgeting, problem solving, searching for housing, locating transportation and using personal services and supports. Guardianship issues may need to be addressed. The person might be leaving a close friend behind or might want to join a roommate in a community. The MFP participant will need to be introduced to older adults and/or persons with similar disabilities living successfully in the community. It will be necessary to link the MFP participant to available community resources including Area Agency on Aging (AAA), Aging and Disability Resources Connections (ADRC) and Centers for Independent Living (CILs). It will be necessary to link the MFP participant to a primary care provider if she/he doesn't already have one. It will be necessary to be sure the MFP participant has at least a 30 day supply of medications on the day of discharge. The ITP should include transition activities to assist the person in adjusting to resettlement. For example, if separating from a close friend, there may need to be a plan for the person to make contact with the friend either by phone or by personal visit, or by email/mail, etc. Such an approach recognizes the importance of the MFP participant's existing support network while assisting the person to make new relationships in the community.
5. Personal Goals/Desired Outcomes from Transition: List the participant's goals and personal assets/strengths. List barriers to resettlement identified by the participant, family and/or friends. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to remove listed barriers.
6. Health/Nutrition Goals: List health and nutrition goals; recommended medical follow-up; allergies; current medications/dosages, self-administration of meds; lifting/positioning needs; type of diet; dietary restrictions (food allergies, low cholesterol etc.); food intake/preferences; food preparation strategies and dietary restrictions. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve health and nutrition goals.
7. 24/7 Emergency Backup Plan: identify risks to the MFP participant's health and safety based on resettlement choice of residence type. For each identified risk to health and safety in the preferred community living environment, develop an individualized contingency plan for emergency back-up. The ITP must include plans for equipment failures, transportation failures, natural disasters, power outages and interruptions in routine care. This information should be gathered and put into a notebook (or something similar) so that the participant will be able to access it in time of emergency. In the notebook or similar, provide the participant with 24/7 emergency phone contacts for case manager and service providers. Vendors/agencies are required to provide 24/7 backup for direct care staff and to

instruct direct care staff on participant needs and preferences. MFP participants using participant-directed options must identify at least two individuals (i.e. friends, family members, etc) in their emergency plans to assist them in the event that routine care staff doesn't show up.

8. Vision/Hearing/Mobility Goals: List vision, hearing and personal mobility goals of the participant, and the impact of current functioning on activities of daily living (ADLs); list durable medical equipment that the participant is currently using or that will be need to maximize current functioning. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve vision, hearing and personal mobility goals. If this area does not apply to the participant, check the N/A checkbox.
9. Communication Goals: List the communication goals of the participant, the methods that participant uses to communicate (verbal, non-verbal, uses gestures, communication board, AAC device, assistive telephone technology, TTY, etc.); any specific signals a person may give to communicate (ex. "whine" means doesn't feel well; "hand to head" means headache, etc.). List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve communication goals. If this area does not apply to the participant, check the N/A checkbox.
10. Affective/Social/Recreational Goals: List the participant's leisure and recreation interests/preferences and goals. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve social and recreational goals. If this area does not apply to the participant, check the N/A checkbox.
11. Self Care (Domestic and Personal) Goals: List the participant's self care goals, interest in self-directing personal services and supports workers, the degree of personal independence; amount/type of assistance needed for activities of daily living in personal care (eating, dressing, hygiene, etc.); and domestic skills (meal preparation, laundry, budgeting, etc.). List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve self care goals, including self-direction of personal services and supports workers. If this area does not apply to the participant, check the N/A checkbox.
12. Adaptive Equipment Use and Needs: What adaptive devices is the participant currently using to maintain the current level of functioning? What is the availability of the devices? Will they move with the person or will they need to be procured? List personal assets/strengths, resources offered by friends and family, MFP/waiver services and community programs and services available to assist the

person with adaptive equipment needs. If this area does not apply to the participant, check the N/A checkbox.

13. Barriers and Facilitators to Community Participation: List the independent living community skills, strengths or degree of independence in use of money to purchase services; travel; use of community facilities and services; basic safety awareness/skills. List personal assets/strengths, resources offered by friends and family, MFP/waiver services and community programs and services available to assist the person to achieve higher degrees of independent living community skills.
14. Vocational Goals: Work goals, interests, skills, and attitudes; type of work performed and future options; amount and type of assistance needed to perform the job; barriers to gainful employment. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve vocational goals. If this area does not apply to the participant, check the N/A checkbox.
15. Transportation Needs and Barriers to Access: List the transportation needs the participant may have. Is a wheelchair accessible van needed, does the person require accompanying staff to assist or is the participant independent? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to achieve independent transportation goals. If this area does not apply to the participant, check the N/A checkbox.
16. Financial Goals: Are the appropriate people (the participant, TCs, CMs, CC/SB) aware of and familiar with the SSI/SSDI transfer issues and the involvement DFACS at DCH in Atlanta? Atlanta DFACS will terminate the institutional enrollment and change the participant's eligibility status from institutional to HCBS/Waiver. Are there any outstanding financial issues? What about unpaid utility bills? If unpaid utility bills from the past are preventing the person from transitioning, consult with the county DFACS office for programs to assist the participant to pay off these old utility bills. List the participant's financial goals. List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to resolve financial issues and achieve financial goals. Assist the person to develop a budget for community living (see #22 Income and Resources-Budget for Community Living). Establish how the MFP participant will pay for rent, utilities, food, transportation, medicines, recreation, etc.? If this area does not apply to the participant, check the N/A checkbox.
17. Legal Issues: Are there legal issues to consider? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to resolve these legal issues. If this area does not apply to the participant, check the N/A checkbox.

18. Family/Guardian Involvement Issues: Who is involved and what is the relationship? How often does contact occur; type of contact (phone calls, visits, etc.); person's response to interaction with family/guardian. Does the participant want to terminate guardianship? List personal assets/strengths, resources offered by friends and family, MFP and waiver services and community programs and services available to assist the person to resolve family/guardian involvement issues. If this area does not apply to the participant, check the N/A checkbox.
19. Part A: MFP Pre- and Post-Transition Services: List the MFP Pre-and Post-Transition Services selected by the participant/team in the Table provided, along with the justification for each service selected. Why is the services needed? How will it be used to support successful living in the community? How much will it cost? Are the costs within the maximum allowed for the service? The participant initials each MFP service selected.
20. Transition Plan/Assignments: Pre-transition, post-discharge or follow-up activities that need to occur for a smooth transition and continuity of care and services to occur. Include specific names of persons (when possible) that are assigned to implement the ITP.
21. Follow-up Plan: This should be completed to specify what follow-up is to be given, when and by whom.
22. Income and Resources-Budget for community living: Based on the information obtained about the participant's Income and Resources from the MFP Screening Form, discuss and develop a budget for community living with the transition team. Use the space provided to develop a preliminary community living budget.
23. Part B Waiver Services: Using the table provided, identify the waiver services selected by the participant and the waiver case manager. Under "Rationale" describe how the waiver services will work with MFP services to support the participant in the community. Why is the services needed? How will it be used? The member initials each waiver service selected.
24. Part C Other Services: Using the table provided, identify State Plan and/or Other Services selected by the participant and the team. Under "Rationale" describe how State Plan and/or Other Services will work with MFP services to support the participant in the community. Why is the services needed? How will it be used? The member initials each service selected.
25. ITP Signature Page: Each member of the transition team signs the signature page.

Note: the participant's learning style/preferences (what works best with this participant) should be incorporated in each domain as applicable.

Note to TCs: Send the completed ITP to the DCH/MFP Office via File Transfer Protocol (FTP) or by fax.

APPENDIX R



DISCHARGE DAY CHECKLIST



Revised 081310

Transition Coordinator Name/Phone #:		Date:
MFP Participant Information		
Name:		Date of Birth:
New Address:		Phone Number
City:	Zip:	Change Of Address Notification To:
<input type="checkbox"/> Apt/house leased by Participant <input type="checkbox"/> Home owned by Participant <input type="checkbox"/> Apt/house leased by Family Member <input type="checkbox"/> Home owned by Family Member		<input type="checkbox"/> DFCS <input type="checkbox"/> Social Security <input type="checkbox"/> Other (Please List) <input type="checkbox"/> Lic. Residential Care Setting with 4 or less residents <input type="checkbox"/> Lives with family members (check for yes)
Individualized Transition Plan (ITP)		
Item Key: N=Needed; O=Ordered; P=Purchased; N/A=Not Applicable		
Items (provide items for all that apply): ___ Home: ___ Modifications; ___ Security Deposit; ___ Utility Deposits: _____; ___ Other: _____ ___ Household items: ___ Kitchen: _____; ___ Bath: _____; ___ Bed: _____ ___ Food & Nutrition: _____ ___ Health & Hygiene: _____ ___ RX Medications: _____ ___ Medical Services/Equipment: _____ ___ Assistive Technology Devices: _____ ___ Life Skills/ Socialization: _____ ___ Financial: _____ ___ Transportation: _____ ___ Other:(list) _____		
Waiver:	Waiver Case Manager/Care Coordinator:	Phone:
List services ordered at discharge: _____; _____; _____; _____; _____; _____;		
Are providers identified to begin services upon discharge?: <input type="checkbox"/> Yes <input type="checkbox"/> No* *Explain: _____		
Name of Community Pharmacy: _____		
24/7 Emergency plan reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No* *Explain: _____		
Please identify participant's needs upon discharge and the plan to meet the participant's need: (attach additional sheets as needed)		
Follow-up Visits/Quality Management		
Home Visits: Please provide schedule for follow up visits.		
<input type="checkbox"/> Transition Coordinator 1 st Scheduled Visit: _____		
<input type="checkbox"/> Waiver Case Manager Name: _____ Phone: _____ 1 st Scheduled visit: _____		
<input type="checkbox"/> LTC Ombudsman Name: _____ Phone: _____ 1 st Scheduled visit (or n/a): _____		
<input type="checkbox"/> County DFCS Office Contact: _____ Phone: _____ Email: _____		
Quality of Life Survey: <input type="checkbox"/> Initial; <input type="checkbox"/> 2 nd Survey; <input type="checkbox"/> Completed: <input type="checkbox"/> Scheduled: <input type="checkbox"/> Rescheduled: _____		
Participant Tracking		
<input type="checkbox"/> This report faxed to _____ <input type="checkbox"/> Status entered into MFP data base		Date:
<input type="checkbox"/> This report faxed to client's Case Manager/Care Coordinator		
By: _____		Title: _____

APPENDIX S



**MFP Authorization for
Pre-and Post-Demonstration Services**



MFP Transition Coordinator (TC)/Case Expediter (CE): complete the following to authorize MFP services for MFP participant transitioning from nursing facility or ICF/MF to MFP qualified residence. .

Participant First Name: _____ **Participant Last Name:** _____
Participant MHN#: _____ **Participant Date of Birth:** _____
Participant Address: _____ **Participant City:** _____ **State:** _____ **Zip:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
Date of Transition Meeting: _____ **COS Waiver Type:** _____
Date of DISCHARGE: _____
CHECK ONLY ONE: this is a(n) **Initial Authorization** **Revised Authorization**

Vendor	Pre Transition Services	\$'s Authorized

Total Pre-Transition \$'s Authorized:

(Pre-transition services are not to exceed \$7844 in the 365 day demonstration period).

Vendor	Post Transition Service	\$'s Authorized

Total Post-Transition \$'s Authorized:

Post-Transition services are not to exceed \$24,118 in the 365 day demonstration period.

Transition Coordinator (TC)/Case Expediter (CE) Name: _____
 TC/CE Region: _____ TC/CE Phone: _____ TC/CE Email: _____

Authorizing Signature: _____ Date Signed: _____

Note to TC/CE: (1) Send this completed *Authorization* to Acumen via **File Transfer Protocol (FTP)**.
 (2) Send this complete *Authorization* to the DCH/MFP Office via File Transfer Protocol or by fax.

MFP Authorization for MFP Services_Revised_031110

APPENDIX T



Quote Form for Equipment & Supplies, Environmental Modification and/or Vehicle Adaptations



TC/CE: complete this *Quote Form* for equipment and supplies costing \$1000 or more, all environmental modifications and/or all vehicle adaptations for MFP participants. This is an internal form for tracking purposes.

Participant First Name: _____ **Participant Last Name:** _____
Participant MHN#: _____ **Participant Date of Birth:** _____
Nursing Facility/Hospital Name: _____
Participant Address: _____ **Participant City:** _____ **State:** _____ **Zip:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
Date(s) of ITP/Planning Meetings: _____ **COS Waiver Type:** _____

Vendor Name/Phone	Post Transition Service	Acumen Code	Quoted Amount	Check Accepted Quote
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

Total \$'s Authorized:

- Maximum allowed Cost for Equipment and Supplies is \$5,000 in the 365 day demonstration period. Three quotes must be obtained before a purchase can be authorized for a single piece of equipment or a single supply costing \$1000 or more.
- Maximum allowed Cost for Vehicle Adaptations is \$6,240 in the 365 day demonstration period. Three quotes must be obtained before Vehicle Adaptations can be authorized.¹
- Maximum allowed Cost for Environmental Modifications is \$8,000 in the 365 day demonstration period. Three quotes must be obtained before Environmental Modifications can be authorized. Environmental modifications can be made to rental property for participants who have a Housing Choice Voucher and to some community homes on a case-by-case basis.¹

Owner Name: _____ **Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Transitional Coordinator (TC)/ Case Expediter Name: _____

TC/CE Region: _____ TC/CE Phone: _____ TC/CE Email: _____

Authorizing Signature: _____ Date Signed: _____

¹ Environmental Modifications and Vehicle Adaptations must include a notarized document giving the owner's permission for services, if the owner is not the member.

Notes to TC/CEs: (1) Send this completed *Quote Form* to Acumen via **File Transfer Protocol (FTP)**. (2) Send this completed *Quote Form* to the DCH/MFP Office via File Transfer Protocol (FTP) or by fax.

MFP_Quote_Form_EQS_VehAD_EnvMods_Revised_091109

APPENDIX U



Vendor Payment Request to TC Money Follows the Person



MFP Services Rendered for:

Participant/Consumer Name:	Participant/Consumer/Contact Phone:
Participant/Consumer Address:	Participant/Consumer City/State/Zip

Transition Coordinator Use Only	
Participant/Consumer MHN#:	Participant/Consumer Date of Birth:

PAYMENT INSTRUCTION

Vendor Name:	Vendor Phone:
MAIL CHECK TO (if different):	Vendor Tax ID, FEIN or SS#:
Vendor Address:	Vendor City/State/Zip

DESCRIPTION OF MFP PRE/POST-TRANSITION SERVICES

Date	Description	Billed Amount
Total Check Amount		

By signing this form, I attest that services were delivered and received consistent with the Individual Transition Plan. I understand that Medicaid is the payer of last resort.

_____ **MFP Participant Signature** _____ **Date**

_____ **Vendor Signature** _____ **Date**

Fax or mail to MFP Transition Coordinator Name: _____

TC Phone: _____ TC Fax: _____

MFP TC Address: _____

City: _____ State: _____ Zip: _____

Note to Vendor: fax or mail this completed form to the Transition Coordinator listed above. **Note to TC:** once verified, send this completed form to Acumen via File Transfer Protocol. Send this completed form to the DCH/MFP office via File Transfer Protocol or by fax.

DCH/MFP Vendor Payment Request To TC_Revised_030909

APPENDIX W1
Transition Document Submission Instructions

Transition documents for each MFP participant are submitted in. PDF, .DOC or .RTF format, as soon as possible (ASAP). These documents include but are not limited to the following:

- *Authorization for Use or Disclosure of Health Information* (see Appendix D1)
- *MFP Consent for Participation* (see Appendix D2)
- *MFP Transition Screening Form* (see Appendix G)
- *Individualized Transition Plan (ITP)* (see Appendix Q1)
- *Authorization for MFP Services* (see Appendix S)
- *Quote Form for Equipment & Supplies, Environmental Mods, and Vehicle Adaptations* (See Appendix T)
- *Vendor Request For Payment To TC* (see Appendix U)
- *Referral Letter for Housing Choice Voucher* (see Appendix AA)
- *MFP Vendor Import File* (see Appendix V)
- *Discharge Day Checklist* (see Appendix R)
- *MFP Sentinel Event Report* (see Appendix AB)
- *Participant Enrollment Status Change* (see Appendix Y)

APPENDIX W2

Monthly Report of Persons Served Monthly Report of Completed QoL Surveys Monthly Update of MFP HCV Program Participation

Monthly Report of Person Served

The Contractor is responsible for submitting the cumulative results in a report to DCH monthly by the 15th of the month, for the previous month; with the data listed below for each individual screened and transitioned into the MFP demonstration. The Contractor submits the requested data on a formatted Excel Spreadsheet for this report.

- Participant First and Last Name
- Participant Date of Birth
- Participant Medicaid Number
- Participant Target Population
- Nursing Facility/Institution Name (facility participant transferred from)
- Date of completed screening (actual face-to-face screening date for each participant and friends/family)
- Date of completed Individualized Transition Plan (ITP/PCD)
- Date of referral to waiver
- Date of waiver application approval (date participant is accepted into waiver, service start date)
- Date of baseline Quality of Life Survey
- Date of discharge (actual date participant was discharged from the facility)
- MFP Pre-transition services authorized – total amount authorized to date for all pre-transition services
- MFP Pre-transition service expenditures – total amount spent to date for all pre-transition services
- MFP Post-transition services authorized – total amount authorized to date for all post-transition services
- MFP Post-transition service expenditures – total amount spent to date for all post-transition services
- Participant-Directed options and participant's selection
- State Plan Services recommended and or received
- Participant Status – deceased, ineligible for MFP, refused MFP, etc.
- Date of re-institutionalization (if applicable)
- Reason for re-institutionalization (if applicable)
- Date of 30 day follow up (actual face-to-face follow-up completed)
- Signature and date

Monthly Report: Completed QoL Surveys

MFP Quality of Life File must be submitted as an Excel file to the MFP Office via secure FTP transmission. The survey software provided by MPR will produce the file in the proper format.

Monthly Update of MFP HCV Program Participation

TCs submit the following information on each MFP HCV participant:

- Participant Last Name, First Name
- Participant SSN (last 4 digits)
- Responsible TC
- Preferred County of Residence
- Date *MFP Referral Letter for DCA Housing Choice Voucher Program* (see Appendix AA) faxed to DCH MFP office
- Date Completed HCV application sent to DCA Regional Office
- Date of HVC Voucher Briefing
- Date of HQS Inspection
- Date of Passed Inspection/HAP Contract Begins

MFP/DCH_Monthly Report of Persons Served_122209

APPENDIX W3

Quarterly Report of MFP Program Activities

Transitions						
		Target Populations				
		Older Adults	PD	ABI	DD	Other:
1	Number of screenings completed (includes completed <i>MFP Transition Screening Form, Informed Consent, and Release of Information Forms</i>) during this reporting period					
2	Number of screenings completed that didn't end in enrollment into/referral to an appropriate waiver					
3	Number of completed <i>Individualized Transition Plans (ITP/PCD)</i> (Persons Centered Planning, Authorization for MFP Services, HCBS Waiver Services) during this reporting period					
4	Number of transitions originating from nursing facilities, during this reporting period					
5	Number of transitions originating from other facilities/institutions, during this reporting period, specify: _____					
6	Number of MFP re-institutionalizations by reason during reporting period Acute care event (e.g., hip fracture) Lack of appropriate housing Loss of primary caregiver Loss of informal supports Insufficient supply of personal care workers Service needs greater than what can be provided Guardian request Participant request Unknown Other, specify _____					
7	Number of MFP participants who completed one-year transition period during reporting period					

Challenges	
8	Are you having difficulty transitioning the projected number of persons planned for the targeted population? [yes/no]
9	If yes, which target populations? <input type="checkbox"/> Older Adults <input type="checkbox"/> Participants with physical disabilities <input type="checkbox"/> Participants with ABI <input type="checkbox"/> Participants with Developmental Disabilities <input type="checkbox"/> Other, specify _____
10	Please describe your difficulties for each target population? (Attach additional pages)

Demonstration Policies and Procedures																																																	
Participant Recruitment and Enrollment																																																	
11	Did anything change during the reporting period that made recruitment easier? [yes/no]																																																
12	If yes, what changed? Indicate reason by target population. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 10%;">Older Adults</th> <th style="width: 10%;">PD</th> <th style="width: 10%;">ABI</th> <th style="width: 10%;">DD</th> <th style="width: 10%;">Other:</th> </tr> </thead> <tbody> <tr> <td>Type or quality of data available for identification</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>How data are used for identification</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Obtaining provider/agency referrals</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Obtaining self referrals</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Obtaining family referrals</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Assessing needs</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other, specify</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Older Adults	PD	ABI	DD	Other:	Type or quality of data available for identification						How data are used for identification						Obtaining provider/agency referrals						Obtaining self referrals						Obtaining family referrals						Assessing needs						Other, specify					
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Other, specify																																																	
13	Please describe the changes for each population (Attach additional pages)																																																
14	Did you experience significant challenges during this reporting period recruiting for the MFP Project? Significant challenges are those that affect ability to transition as many people as planned. [yes/no]																																																

15	If yes, what types of challenges were experienced? Indicate reason by target population		Older Adults	PD	ABI	DD	Other:
		Type or quality of data available for identification					
		Obtaining provider/agency referrals or cooperation					
		Obtaining self referrals					
		Obtaining family referrals					
		Screening needs					
		Lack of interest among people targeted or their families					
		Unwilling to consent to program requirements					
	Other, specify						
16	Please describe the challenges for each population and what are you doing to address the challenges? (Attach additional pages)						
17	Did anything change during the reporting period that made enrollment into the MFP program easier? [yes/no] These changes may be the result of changes in the Medicaid policies and procedures or home community based waiver programs.						
18	If yes, what changed? Check all that apply by target population.		Older Adults	PD	ABI	DD	Other:
		Determination of initial eligibility					
		Re-determination of eligibility after a suspension due to re-institutionalization					
		Other, specify					
19	Please describe what made enrollment easier for each population (Attach additional pages)						
20	Did you experience significant challenges enrolling individuals? Significant challenges are those that affect the ability to transition as many people as planned.[yes/no]						
21	If yes, what types of challenges did you experience? Check all that apply by target population		Older Adults	PD	ABI	DD	Other
		Determination of initial eligibility					
		Reestablishing eligibility after a suspension due to reinstitutionalization					
		Other, specify					
22	Please describe the changes for each population and what are you doing to address the challenges? (Attach additional pages)						

23	Please indicate the total number of MFP candidates screened in this period, or a prior reporting period, who are currently in the transition planning process, that is "in the pipeline," and expected to enroll in MFP.		Older Adults	PD	ABI	DD	Other	
		Number of MFP candidates screened, who are in process						
24	Please indicate the total number of MFP candidates that completed MFP screening, but did not transition this period.		Older Adults	PD	ABI	DD	Other	
		Number of MFP candidates screened, but not transitioned this period						
25	How many individuals could not be enrolled in the MFP program for each of the following reasons:		Older Adults	PD	ABI	DD	Other:	
		Individual(s) transitioned to the community, but was not enrolled in MFP or was ineligible for MFP						
		Individual's physical health needs exceeded capacity of program to meet them						
		Individual's mental health needs exceeded capacity of program to meet them						
		Guardian refused participation						
		Could not locate appropriate housing arrangement						
		Could not secure affordable housing						
		Individuals did not choose MFP qualified residence						
		Individual changed his/her mind						
		Individual would not cooperate in care plan development						
		Service needs greater than what could be provided in the community						
		Other, specify						
If necessary, please explain further why individuals could not be transitioned or enrolled in the MFP program.								
26	Please indicate the number of MFP participants transitioned during this period whose length of time from screening to actual transition took: ___ less than 2 months ___ 2 to 6 months ___ 6 to 12 months ___ 12 to 18 months ___ 18 to 24 months ___ 24 months or more Please indicate the average length of time required from screening to actual transition.							

27	Percent of MFP participants whose length of time from MFP screening to actual transition took: <input type="checkbox"/> % less than 2 months <input type="checkbox"/> % 2 to 6 months <input type="checkbox"/> % 6 to 12 months <input type="checkbox"/> % 12 to 18 months <input type="checkbox"/> % 18 to 24 months <input type="checkbox"/> % 24 months or more																																				
Informed Consent and Guardianship																																					
28	Did anything change during the reporting period that made obtaining informed consent easier? [yes/no]																																				
29	If yes, what changed? Indicate reason by target population. <table border="1"> <thead> <tr> <th></th> <th>Older Adults</th> <th>PD</th> <th>ABI</th> <th>DD</th> <th>Other:</th> </tr> </thead> <tbody> <tr> <td>Revised inform consent documents and/or forms</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Provided more or enhanced training for transition coordinators</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Improved how guardian consent is obtained</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other, specify</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Older Adults	PD	ABI	DD	Other:	Revised inform consent documents and/or forms						Provided more or enhanced training for transition coordinators						Improved how guardian consent is obtained						Other, specify											
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Other, specify																																					
30	Please describe what made obtaining informed consent easier by target population (Attach additional pages)																																				
31	Did anything change during the reporting period that improved or enhanced the role of guardians? [yes/no]																																				
32	If yes, what changed? Indicate reason by target population. <table border="1"> <thead> <tr> <th></th> <th>Older Adults</th> <th>PD</th> <th>ABI</th> <th>DD</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>How guardians are involved in transition planning</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Communication and frequency of communication with guardians</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>How guardians are involved in ongoing care planning</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>How guardians are trained and mentored</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other, specify</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Older Adults	PD	ABI	DD	Other	How guardians are involved in transition planning						Communication and frequency of communication with guardians						How guardians are involved in ongoing care planning						How guardians are trained and mentored						Other, specify					
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Other, specify																																					
33	Please describe what improved or enhanced the role of guardians by target population (Attach additional pages)																																				
34	Did you experience <i>significant</i> challenges obtaining informed consent or meeting guardianship requirements? Significant challenges are those that your ability to transition as many people as planned. [yes/no]																																				

35	If yes, what types of challenges have you experienced? Indicate reason by target population.		Older Adults	PD	ABI	DD	Other:
		Ensuring informed consent					
		Involving guardians in transition planning					
		Communicating and the frequency of communication with guardians					
		Involving guardians in ongoing care planning					
		Training and mentoring of guardians					
	Other, specify						
36	Please describe the challenges you experienced for each population (Attach additional pages)						
37	What are you doing to address the challenges?						
Outreach, Marketing, and Education							
38	Are there any notable achievements in outreach/marketing/education during the reporting period [yes/no]						
39	If yes, what was the achievement(s) in? Check all that apply <input type="checkbox"/> Development of print materials <input type="checkbox"/> Implementation of a localized/targeted media campaign <input type="checkbox"/> Implementation of a statewide media campaign <input type="checkbox"/> Involvement of stakeholder state agencies in outreach and marketing <input type="checkbox"/> Involvement of discharge staff at facilities <input type="checkbox"/> Involvement of LTC Ombudsman <input type="checkbox"/> Training of frontline workers on program requirements <input type="checkbox"/> Other, specify						
40	Please describe the achievements in outreach/marketing/education for each population for the reporting period (Attach additional pages)						
41	Did you experience <i>significant</i> challenges conducting outreach, marketing, and education activities as planned during the reporting period? [yes/no]						

42	<p>If yes, what types of challenges did you experienced? Check all that apply</p> <p><input type="checkbox"/> Development of print materials</p> <p><input type="checkbox"/> Implementation of a localized/targeted media campaign</p> <p><input type="checkbox"/> Implementation of a statewide media campaign</p> <p><input type="checkbox"/> Involvement of stakeholder state agencies in outreach and marketing</p> <p><input type="checkbox"/> Involvement of discharge staff at facilities</p> <p><input type="checkbox"/> Involvement of LTC Ombudsman</p> <p><input type="checkbox"/> Training of frontline workers on program requirements</p> <p><input type="checkbox"/> Other, specify _____</p>
43	<p>Please describe the challenges you experienced in outreach/marketing/education for each population during the reporting period (Attach additional pages)</p>
44	<p>What are you doing to address the challenges?</p>
<p>Community Involvement</p>	
45	<p>Which of the following community groups did you involve in the program during the reporting period? Check all that apply.</p> <p><input type="checkbox"/> Consumers</p> <p><input type="checkbox"/> Families</p> <p><input type="checkbox"/> Advocacy organizations</p> <p><input type="checkbox"/> HCBS providers/associations</p> <p><input type="checkbox"/> Institutional providers/associations</p> <p><input type="checkbox"/> Labor/worker associations</p> <p><input type="checkbox"/> Other state agencies, except housing</p> <p><input type="checkbox"/> Public housing agency(ies)</p> <p><input type="checkbox"/> Nonprofit housing organizations</p> <p><input type="checkbox"/> Other, specify _____</p>

46	<p>How was each community group involved in the program during the reporting period? Check all that apply. (Request a response for each type of stakeholder checked in question above)</p> <p>Community Group involved _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provided input on MFP policies or procedures <input type="checkbox"/> Helped to promote/market MFP program <input type="checkbox"/> Involved in housing development <input type="checkbox"/> Involved in quality of care assurances <input type="checkbox"/> Attended MFP advisory meetings <input type="checkbox"/> Other, specify _____ <p>Community Group involved _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provided input on MFP policies or procedures <input type="checkbox"/> Helped to promote/market MFP program <input type="checkbox"/> Involved in housing development <input type="checkbox"/> Involved in quality of care assurances <input type="checkbox"/> Attended MFP advisory meetings <input type="checkbox"/> Other, specify _____ <p>Community Group involved _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provided input on MFP policies or procedures <input type="checkbox"/> Helped to promote/market MFP program <input type="checkbox"/> Involved in housing development <input type="checkbox"/> Involved in quality of care assurances <input type="checkbox"/> Attended MFP advisory meetings <input type="checkbox"/> Other, specify _____ <p>Community Group involved _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provided input on MFP policies or procedures <input type="checkbox"/> Helped to promote/market MFP program <input type="checkbox"/> Involved in housing development <input type="checkbox"/> Involved in quality of care assurances <input type="checkbox"/> Attended MFP advisory meetings <input type="checkbox"/> Other, specify _____
47	<p>Did you experience <i>significant</i> challenges involving consumers and families in program planning and ongoing program administration? [yes/no]</p>
48	<p>If yes, what types of challenges did you experience? Check all that apply</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identifying willing consumers <input type="checkbox"/> Identifying willing families <input type="checkbox"/> Involving them in a meaningful way <input type="checkbox"/> Keeping them involved for extended periods of time <input type="checkbox"/> Communicating with consumers <input type="checkbox"/> Communicating with families <input type="checkbox"/> Other, specify _____
49	<p>What are you doing to address the challenges?</p>

50	Did you make any progress during the reporting period in building a collaborative relationship with any of the following housing agencies or organizations? Check all that apply <input type="checkbox"/> state agency that sets housing policies <input type="checkbox"/> state housing finance agency <input type="checkbox"/> public housing agency(ies) <input type="checkbox"/> non-profit agencies involved in housing issues <input type="checkbox"/> Other housing organizations (such as, landlords, realtors, lenders, and mortgage brokers) <input type="checkbox"/> Other, specify
51	If yes, please describe the progress made? (Attach additional pages)
52	Did you experienced <i>significant</i> challenges in building a collaborative relationship with any of the agencies involved in setting state housing policies, financing, or implementation of housing programs? [yes/no]
53	If yes, please describe the challenges? (Attach additional pages)

Benefits and Services	
54	Did you experience significant challenges or barriers to guaranteeing that MFP participants can be served in Medicaid HCBS waiver? [yes/no]
55	If yes, what types of challenges or barriers were experienced, please describe by target population? (Attach additional pages)
56	What are you doing to address the challenges?

Participant Access to Services																																																	
57	What are MFP participant's most <i>significant</i> barriers to accessing home and community-based services? These are barriers that either make it difficult to transition as many people as you had planned or make it difficult for MFP participants to remain living in the community. Indicate reason by target population.																																																
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58	Please describe these barriers in detail by target population. (Attach additional pages)
59	What are you doing to address these barriers? Please describe by target population.

Self-Direction																									
60	<p>How many MFP participants were in a self-direction program during the reporting period?</p> <p> <input type="checkbox"/> Older Adults <input type="checkbox"/> Participants with physically disabilities <input type="checkbox"/> Participants with ABI <input type="checkbox"/> Participants with Developmental Disabilities <input type="checkbox"/> Other, specify _____ </p>																								
61	<p>Of those MFP participants in a self-direction program, how many hired or supervised their own personal assistants? How many managed their allowance or budget?</p> <table border="0"> <tr> <td>Hired/Supervised Assistants</td> <td>Managed allowance or budget</td> </tr> <tr> <td> <input type="checkbox"/> Older Adults <input type="checkbox"/> Physically disabled <input type="checkbox"/> ABI <input type="checkbox"/> DD <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Not applicable </td> <td> <input type="checkbox"/> Older Adults <input type="checkbox"/> Physically disabled <input type="checkbox"/> ABI <input type="checkbox"/> DD <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Not applicable </td> </tr> </table>	Hired/Supervised Assistants	Managed allowance or budget	<input type="checkbox"/> Older Adults <input type="checkbox"/> Physically disabled <input type="checkbox"/> ABI <input type="checkbox"/> DD <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Not applicable	<input type="checkbox"/> Older Adults <input type="checkbox"/> Physically disabled <input type="checkbox"/> ABI <input type="checkbox"/> DD <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Not applicable																				
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62	<p>How many MFP participants in a self-direction program during the reporting period reported abuse or experienced an accident? Indicate the number by target population that-</p> <table border="1"> <thead> <tr> <th></th> <th>Older Adults</th> <th>PD</th> <th>ABI</th> <th>DD</th> <th>Other:</th> </tr> </thead> <tbody> <tr> <td>Reported being abused by an assistant, job coach, or day program staff</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Experienced an accident (such as a fall, burn, medication error)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other, specify</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Older Adults	PD	ABI	DD	Other:	Reported being abused by an assistant, job coach, or day program staff						Experienced an accident (such as a fall, burn, medication error)						Other, specify					
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63	Please provide a detailed description? (Attach additional pages)																								
64	<p>How many MFP participants in a self-direction program disenrolled from the program during the reporting period?</p> <p> <input type="checkbox"/> Older Adults <input type="checkbox"/> Participants with physically disabilities <input type="checkbox"/> Participants with ABI <input type="checkbox"/> Participants with Developmental Disabilities <input type="checkbox"/> Other, specify _____ </p>																								

65	<p>Of the MFP participants who were disenrolled from a self-direction program, why were they disenrolled?</p> <p><input type="checkbox"/> Opted-out <input type="checkbox"/> Inappropriate spending <input type="checkbox"/> Unable to self-direct <input type="checkbox"/> Abused their worker <input type="checkbox"/> Other, specify</p>																																										
66	<p>Please provide a detailed description? (Attach additional pages)</p>																																										
<p>Quality Management/ Quality Improvement</p>																																											
67	<p>How many calls did you have from MFP participants for emergency back-up assistance during the reporting period by type of assistance needed? Emergency refers to situations that could endanger the health or well-being of a participant and may lead to a critical incident if not addressed. (Please note this question only captures calls that were considered to be emergencies and not those that are informational or complaints.) Number by population calling regarding:</p> <table border="1" data-bbox="375 793 1255 999"> <thead> <tr> <th></th> <th>Older Adults</th> <th>PD</th> <th>ABI</th> <th>DD</th> <th>Other:</th> </tr> </thead> <tbody> <tr> <td>Transportation: to get to medical appointments</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Life-support equipment repair/replacement</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Critical health services</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Direct service/support workers not showing up</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other, specify</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Total for the reporting period</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Older Adults	PD	ABI	DD	Other:	Transportation: to get to medical appointments						Life-support equipment repair/replacement						Critical health services						Direct service/support workers not showing up						Other, specify						Total for the reporting period					
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68	<p>For what percentage of the calls received were you able to provide the assistance that was needed when it was needed? (done in a timely manner):</p> <table border="1" data-bbox="375 1115 1273 1192"> <thead> <tr> <th></th> <th>Older Adults</th> <th>PD</th> <th>ABI</th> <th>DD</th> <th>Other:</th> </tr> </thead> <tbody> <tr> <td>Percentage of calls that received assistance in timely manner</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Older Adults	PD	ABI	DD	Other:	Percentage of calls that received assistance in timely manner																																			
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69	<p>Have you had to change your back-up services or quality management systems due to an identified problem or challenge in the operation of the back-up system(s)? [yes/no]</p>																																										
70	<p>If yes, please describe the changes you have made, as well as the effectiveness of these changes (attach additional pages).</p>																																										
71	<p>Have you experienced any <i>significant</i> challenges with discovering these quality problems? Significant challenges include difficulty identifying, in a timely fashion, incidents that place a MFP participant at risk/danger to themselves or others. [yes/no]</p>																																										

72	If yes, what types of challenges have you experienced? Indicate reason by target population.																														
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73	Please describe these challenges in more detail by population (attach additional pages).																														
74	What are you doing to address your challenges?																														
75	Have you experienced any <i>significant</i> challenges with remediation of these quality problems? Significant challenges include difficulty acting promptly to address an identified risk/danger at the individual level. [yes/no]																														
76	If yes, what types of challenges have you experienced? Indicate reason by target population.																														
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77	Please provide additional details on remediation challenges by target population (attach additional pages)																														
78	What are you doing to address your challenges?																														
79	Have you experienced any <i>significant</i> challenges with quality improvement processes? Significant challenges include difficulty gathering or analyzing information to identify trends that affect an entire group of MFP participants, or difficulty developing and implementing improvements to prevent or reduce the occurrences of quality issues. [yes/no]																														

80	If yes, what types of challenges have you experienced? Indicate reason by target population.					
		Older Adults	PD	ABI	DD	Other: _____
	Gathering information to identify trends					
	Designing and implementing quality improvements					
	Other, specify _____					
81	Please provide additional details on the types of challenges with quality improvement processes that you have experienced by target population (attach additional pages)					
82	What are you doing to address your challenges?					
83	Did any MFP participant experience a critical incident during the reporting period? Critical incidents include abuse, neglect exploitation; hospitalizations; emergency room visits; deaths; involvement with the criminal justice system; medication errors. [yes/no]					
84	If yes, what critical incidents occurred during the reporting period that required investigation? Indicate reason by target population and number of times this type of critical incident occurred. .					
		Older Adults	PD	ABI	DD	Other: _____
	Abuse					
	Neglect					
	Exploitation					
	Deaths (preventable, questionable, or unexpected)					
	Involvement with the criminal justice system					
	Medication administration errors					
	Hospitalizations					
	Emergency room visits					
	Other, specify _____					
85	Please describe in further detail each critical incident indicated in the question above. Indicate the status of the issue—Resolved; In Progress; Abandoned.					
86	For hospitalizations, approximately how many occurred within 30 days of discharge from a hospital or other institutional setting?					
87	For emergency room visits, approximately how many occurred within 30 days of discharge from a hospital or other institutional setting?					

Housing for Participants						
88	Did you experience <i>significant</i> challenges securing appropriate housing options for MFP participants? Significant challenges are those affecting the ability to transition as many people as planned in the community. [yes/no]					
89	If yes, what types of challenges did you experienced? Check all that apply					
		Older Adults	PD	ABI	DD	Other:
	Lack of information about affordable and accessible housing					
	Insufficient supply of affordable and accessible housing					
	Lack of affordable and accessing housing that is safe					
	Insufficient supply of rental vouchers					
	Lack of new home ownership programs					
	Lack of small group homes					
	Lack of residences that provide or arrange for long term services and/or supports					
	Insufficient funding for home modifications					
	Unsuccessful efforts in developing local or state coalitions of housing and human services organizations to identify needs and/or create housing related initiatives					
	Unsuccessful efforts in developing sufficient funding or resources to develop assistive technology related to housing					
	Other, specify					
90	Please describe the challenges for each population and what you are doing to address the challenges?					
91	How many MFP participants who transitioned to the community during the reporting period moved to each type of qualified residence?					
		Older Adults	PD	ABI	DD	Other:
	Home (owned or leased by individual or family)					
	Apartment (individual lease, lockable access, etc.)					
	Group home or other residence in which 4 or fewer unrelated individuals live					

92	Have any MFP participants received a housing supplement during the reporting period? [yes/no]					
	If yes, what sources have been used for these supplements? Indicate source by target population.					
		Older Adults	PD	ABI	DD	Other:
	202 funds					
	CDBG funds					
	Funds for assistive technology as it relates to housing					
	Funds for home modifications					
	HOME dollars					
	Housing choice vouchers (such as tenant based, project based, mainstream, or homeownership vouchers)					
	Housing trust funds					
	Low income housing tax credits					
	Section 811					
	USDA rural housing funds					
	Veterans Affairs housing funds					
Other, specify						

APPENDIX X



**Request For Additional
MFP Transition Services**



MFP Transition Coordinator (TC)/Case Expediter (CE): To obtain approval for additional MFP Transition Services, complete the following form. Services listed on this form must be needed by the participant and not initially identified in the ITP by the team. The MFP participant initials each additional service.

Participant First Name: _____ **Participant Last Name:** _____
Participant MHN#: _____ **Participant Date of Birth:** _____
Participant Address: _____
Participant City: _____ **State:** GA **Zip:** _____ **Waiver:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
Date of ITP: _____ **Date of Discharge:** _____ **Date of Request:** _____

MFP TRANSITION SERVICE	RATIONALE (provide justification for why this MFP service is needed to support successful living in the community)	MFP PARTICIPANT INITIAL

Transition Coordinator (TC)/Case Expediter (CE) Name: _____

TC/CE Region: _____ **TC/CE Phone:** _____ **TC/CE Email:** _____

Note to TC/CE: (1) Send this completed *Request for Additional MFP Services* to the DCH/MFP Office via **File Transfer Protocol** or by fax. Contact DCH/MFP Office regarding the dispensation of this request. (2) If approved by DCH/MFP Office, submit completed reimbursement documentation (i.e., *Authorization for Pre and Post-Transition Services, Vendor Import File*, etc.) to Acumen via **File Transfer Protocol** and to DCH via File Transfer Protocol or fax.

<p>For DCH/MFP Office Use Only Additional MFP Services Authorized: <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:</p>

APPENDIX Y



MFP Participant Enrollment Status Change Form



MFP Transition Coordinator (TC)/Case Expediter (CE): Complete this form to identify changes in the enrollment status of an MFP participant.

Participant First Name: Participant Last Name:
Participant MHN#: Participant Date of Birth:
Participant Phone Number: Other Contact Name: Other Phone:
Date of Discharge from NF/Institution: Waiver:

Date of Status Change:

Type of Status Change: MFP Participation [] Ended
[] Participant was Re-institutionalized
[] Began (Re-enrollment) or
[] Participant Moved (fill in new address below)

New Address: New City: New Zip:

If enrollment ended, check reason:
[] Completed 365 days of participation (01)
[] Suspended eligibility (02)
[] Reinstitutionalized (03)
[] Died (04)
[] Moved (05)
[] No longer needed services/ didn't meet LoC (06)
[] Other (07)

If re-institutionalized, check reason:
[] Acute care hospital stay and long term rehabilitation (01)
[] Deterioration in cognitive functioning (02)
[] Deterioration in health (03)
[] Deterioration in mental health (04)
[] Loss of housing (05)
[] Loss of personal care giver (06)
[] By request of participant or guardian (07)
[] Lack of sufficient community services (08)

If MFP participant re-enrolled or moved, check type of qualified residence used after move:
[] Home owned by participant (01)
[] Home owned by family member (02)
[] Apartment leased by participant, not assisted living (03)
[] Apartment leased by participant, assisted living (04)
[] Group home of no more than 4 people (05)

Does participant live with family members: [] Yes (01) [] No (02)

Transition Coordinator (TC)/Case Expediter (CE) Name:

TC/CE Region: TC/CE Phone: TC/CE Email:

Note to TC/CE: (1) Send this completed Participant Enrollment Status Change Form to the DCH/MFP Office via File Transfer Protocol or by fax. (2) Send this completed Participant Enrollment Status Change Form to Acumen via File Transfer Protocol (FTP).

MFP/DCH_Enrollment_Status_Change_Form_Revised_021709

APPENDIX Z TRANSPORTATION RESOURCES

Revised 07/31/09

MFP Transportation (Pre-Transition Service); This service assists participants with gaining access to community services and resources required during the pre-transition period and is provided when transportation is not otherwise available. **How It Works:** This service does not replace Medicaid Non-Emergency Transportation or ambulance services. Transportation funds can be used for making trial visits to the community, viewing apartments and personal care homes to find a suitable, qualified residence, obtaining needed documents such as personal identification, and for going home on the date of discharge. **Rate:** One unit = \$12.50 one-way or \$25 round trip, up to \$500 per member, can be a pre-transition service, ends on day 365 of the MFP demonstration period..

Public Transportation: http://www.grta.org/commuter_options/home.htm

Para-transit: Paratransit services may be available in the participant's current or chosen country of residence. Check for paratransit services by county of residence

NET-Non-emergency transportation providers: see *Appendix N: Non Emergency Transportation Broker System*. NET providers by region include North-Southeastrans (1-866-388-9844), Atlanta-Southeastrans (404-209-4000), Central-Southeastrans (1-866-991-6701), East-LogistiCare (1-888-224-7988) and Southwest-Southwest GA Regional Development Center (1-866-443-0761).

Own vehicle Specially designed transportation aids are available to meet transportation needs. These include van lifts and ramps for wheelchairs and scooters and/or driving controls that can be installed in SUVs, vans, pickups and cars. If the participant or participant's family own a vehicle, MFP funds can be used to adapt the vehicle for the participant's use. The Vehicle Adaptation service provides funding to assist participants to pay for vehicle adaptation to a vehicle that is privately owned by the participant or their family. **How It Works:** The TC assists the participant to obtain three quotes for the needed adaptations. Vehicle adaptations include the installation of driving controls (when applicable), a lift or ramp for wheelchair or scooter access, wheelchair tie-downs and occupant restraints, special seats or other modifications that are needed to provide for the safe access into and out of and operation of the vehicle. This service does not cover repairs to the vehicle or to the adaptations once they are installed and operational. **Rate:** There is a maximum of \$6,240 available during the 365 day demonstration period. Three quotes must be obtained for all vehicle adaptations. Refer to Section 605.6 for instructions on completing the quote form. Additionally, if the owner of the vehicle is not the participant, a notarized letter giving the owner's permission for the adaptations must be obtained.

Dial-a-ride: check for this program in county of residence

Rural 5311 transportation providers Rural communities with 50,000 residents may have access to DOT 5311 transit providers. Some 5311 transit providers have vans with lifts. Contact local County Commissioner's offices for more information.

Transportation from family, friends, volunteers, church members, etc

Georgia Department of Vocational Rehabilitation: <http://www.vocrehabga.org/>

Community based agencies with low-cost transportation options (FODAC, etc.):
<http://www.fodac.org/>

APPENDIX AA



Georgia Money Follows the Person

Georgia Department of Community Health • Medical Division • Office of Long-Term Care
Two Peachtree Street, NW • 37th Floor • Atlanta, GA 30303 • 404-657-9323

MFP Referral Letter for the Department of Community Affairs (DCA), Housing Choice Voucher Program

Date of Referral Letter Submission: _____

This letter serves as official correspondence for the MFP direct referral process for the DCA, *Housing Choice Voucher Program*. The MFP participant (print name), _____, is being referred for application to the DCA *Housing Choice Voucher Program* by the MFP Transition Coordinator (TC print name), _____.

The Department of Community Affairs (DCA) has entered into an agreement to assist MFP participants with rental assistance vouchers upon approval of the *Application for Housing Choice Voucher Rental Assistance*. The Department of Community Health (DCH) in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Department of Human Services, Division of Aging Services (DHS/DAS) will provide the MFP participant with MFP transition services, Medicaid Home and Community services (waiver services) and State Plan services for which they are eligible and that are appropriate to meet their needs, including non-Medicaid federally funded services, state funded programs and local community funded services. DCH (the Partnering Resource Agency) and the Department of Community Affairs, Housing Choice Voucher Program will collaborate to ensure that the MFP participant has the best opportunity for successful outcomes in the community.

The MFP participant/family has been screened, selected and referred by the MFP Transition Coordinator and is hereby requesting an application for participation in the *DCA Housing Choice Voucher Program* in the following county: _____ (print county where MFP participant wishes to resettle**). The MFP participant's discharge date is: _____.

MFP Participant Information (Print)

First Name: _____ MI: _____ Last Name: _____
SSN: _____ -- ____ -- _____ # in Household (include PCA if applicable) _____

MFP Transition Coordinator Information

(Note: the *Application for the Housing Choice Rental Assistance* will be mailed to TC. When the TC receives the Housing Choice Voucher Application packet, **the TC and MFP member have only 14 business days to complete and mail the completed application to the appropriate DCA Regional Office.** (This will be the same DCA Regional Office that the application was mailed from).

Transition Coordinator Contact (Print) (address for all correspondence)

TC Name: _____ Phone: _____
TC Mailing Address: _____
City/State/Zip Code: _____

The signature below indicates agreement and understanding of terms and expectations set forth in this official MFP referral for the *DCA Housing Choice Voucher Program*. Based on this official correspondence, the MFP participant is formally requesting a *DCA Application for Housing Choice Rental Assistance* for the number of household members listed above.

Signature of MFP Participant Requesting Application _____

Note to TC: Complete and send this MFP referral letter to the Department of Community Health/MFP office via File Transfer Protocol (FTP), by fax or mail to:

RL Grubbs, Money Follows the Person
2 Peachtree Street NW, 37th Floor, Atlanta, Georgia 30303
(404) 657-9323 (voice) (404) 656-8366 (fax)

** Counties not included in the DCA Housing Choice Voucher Program: Fulton, Clayton, Dekalb, Sumter, Chatham, Cobb, Richmond, Glynn, Muscogee and Bibb.

MFP_Referral_DCAHousingChoiceVoucherPgm_Revised_081710

APPENDIX AB



MFP Sentinel Event Report



TC/CE: complete this form when an MFP participant experiences a sentinel event. An individual is considered an MFP participants if (s)he or their guardian has signed the MFP Consent for Participation form.

Date of Report:

Participant First Name:

Participant Last Name:

Participant MHN#:

Participant Date of Birth:

Nursing Facility/Hospital/ICFMR Name (or n/a):

Participant Address:

Participant City:

State:

Zip:

Participant Phone Number:

Other Contact Name:

Other Phone:

Provider (if applicable):

Date of Incident:

Time of Incident:

Location of Occurrence:

Abuse or potential abuse identified? Yes No

Detailed summary of event:

Adverse outcomes related to the event: (Any injuries?) Describe in detail.

Witnesses to the event:

Action taken by Transition Coordinator at time of event:

MFP/DCH_Sentinel_Event_Report_Revised_022609



MFP Sentinel Event Report



Action Plan: (How can this event be prevented from happening in the future?)

Process improvement:

What processes were instituted to evaluate the effectiveness of the action plan and reduce risk to the participant?

Define follow-up time frames for evaluating effectiveness of processes.

Notification:

	Name	Date	Time
Supervisor Notified			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician Notified			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Guardian/Family Notified			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
DCH Notified			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
DHR Notified			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other Agencies Notified			
<input type="checkbox"/> Yes <input type="checkbox"/> No			

TC/CE Signature: _____ Date:

****Please keep a copy for your records and mail a copy to DCH MFP Office****

MFP/DCH_Sentinel_Event_Report_Revised_022609

APPENDIX AC

NOTICE OF DENIAL OR TERMINATION FROM THE MONEY FOLLOWS THE PERSON PROGRAM

To: _____ Date: _____

Your participation in the Money Follows the Person (MFP) program has been given careful consideration. In accordance with the Money Follows the Person Operational Protocol, the following determination has been made:

A. Based on initial screening, you have been determined **ineligible** for MFP because¹:

- You have not resided in an inpatient facility (nursing home, ICF/MR, etc.) for at least six months.
- You have not been receiving Medicaid benefits for inpatient services provided by an inpatient facility.
- You do not require the level of care provided in an inpatient facility.
- You have informed us that you do not wish to participate in the MFP program.
- Existing supports are insufficient to ensure your health and safety in the community because:

B. You have been determined **no longer eligible** for MFP because¹:

- You are no longer receiving Medicaid benefits.
- You have moved to a non-qualified residence².
- You no longer meet institutional level of care criteria.
- You have informed us that you no longer wish to participate in the MFP program.
- You have moved outside of the service area for the State of Georgia.

MFP Transition Coordinator Signature

MFP Transition Coordinator (Print)

Telephone Number

¹ Deficit Reduction Act of 2005, Money Follows the Person Rebalancing Demonstration, Pub. L. No. 109-171, § 6071(b)(2), 120 Stat. 103 (2006).

² Qualified Residence is defined as follows: (A) A home owned or leased by the individual or the individual's family member; (B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and (C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside. Deficit Reduction Act of 2005, Money Follows the Person Rebalancing Demonstration, Pub. L. No. 109-171, § 6071(b)(6), 120 Stat. 103 (2006).

MFP/DCH_Denial_Term_Letter_Rev_111709

If you disagree with this decision, you may request a fair hearing. Your request for a hearing must be received by the Department of Community Health within 30 calendar days from the date of this letter. Your request should be sent to the following address:

Department of Community Health
Legal Services Section
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

NOTICE OF YOUR RIGHT TO A HEARING

To request a hearing, you must ask for one in writing. Your request for a hearing must be *received* by the Department of Community Health within 30 calendar days from the date of this letter. You must include a copy of this Notice of Denial letter from the Money Follows the Person Transition Coordinator. Your request should be sent to the following address:

Department of Community Health
Legal Services Section
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

If you want to keep your services, you must send a written request for a hearing to the Department of Community Health. Your request for a hearing must be *received* by the Department within 30 calendar days from the date of this letter. If this action is sustained by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.

The Office of State Administrative Hearings will notify you of the time, place, and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member speak for you. You may also ask a lawyer for help. You may be able to get legal help at no cost. If you want a lawyer to help, you may call one of these numbers:

Georgia Legal Services Program

800-498-9469 (statewide legal services, except for the counties served by Legal Aid)

Georgia Advocacy Office

800-537-2329 (statewide advocacy for persons with disabilities or mental illness)

Atlanta Legal Aid

404-377-0701 (DeKalb/Gwinnett Counties), 770-528-2565 (Cobb County)

404-524-5811 (Fulton County), 404-669-0233 (S. Fulton/Clayton County)

State Ombudsman Office

888-454-5826 (Nursing Homes or Personal Care Homes)

MFP/DCH_Denial_Term_Letter_Rev_111709

APPENDIX AD



DBHDD



Money Follows the Person



DATE

PARTICIPANT NAME

PARTICIPANT ADDRESS

PARTICIPANT CITY, STATE ZIP

Dear **PARTICIPANT NAME**,

On **DATE**, you discharged from a nursing home or other long-term care facility into the community through the Money Follows the Person (MFP) Demonstration Program. Participation in MFP is limited to 365 calendar days.

Your 365 days of enrollment in MFP will end on **DATE**. The services available through MFP, such as moving expenses, rent and utility deposits, paid peer support, furnishings, durable medical equipment, monthly Ombudsman visits, etc. will end on **DATE**. The regular monthly contact you receive from your Transition Coordinator, **TC NAME**, will end as well.

However, you will continue to receive waiver services through the Medicaid HCBS Waiver, **NAME OF WAIVER**, so long as you continue to meet eligibility criteria for that waiver. Please contact **NAME OF WAIVER CASE MANAGER** at **CASE MANAGER PHONE NUMBER** if you have any questions regarding your waiver services.

In the near future, you will be contacted by a representative from the Georgia State University Georgia Health Policy Center. This representative will be calling to conduct a follow-up to the Quality of Life survey you responded to before you left the long-term care facility. Your responses to the survey questions are extremely important to the success of the Money Follows the Person program, and we appreciate your time and your feedback about the MFP services you received.

Thank you for participating in the Money Follows the Person Demonstration. If you have any questions about this letter, you may contact your Transition Coordinator at the number below, or you may call the MFP State Office at the Georgia Department of Community Health Medicaid Division at 404-651-6889.

Sincerely,

NAME OF TRANSITION COORDINATOR

CONTACT PHONE # FOR TC

MFP ENROLLMENT END LETTER_081710