

**February 4 – 5, 2013
MFP Process Orientation
Workshop**



Macon, Georgia

**Georgia Department of Community Health
Medicaid Division/Aging and Special Populations
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303**



**Money Follows the Person
2013 Process Orientation Workshop
February 4 – 5, 2013 Macon, GA**

Day One

Time	Topic	Presenter
9:30 Opening	Welcome and Workshop Evaluation	Pam Johnson
9:45 Plenary	“Person Centered Planning”-	Cheryl Harris Amy Riedesel
10:15 MFP Process and Participant Assessment	Logic Model and Quality of Life Survey	Kristi Fuller
10:45 BREAK	BREAK	
11:00 -Noon Eligibility	-Referrals -Denials -Terminations	DAS and DCH

LUNCH – Speaker Dawn Alford /”Dignity of Risk”

1-3:00 Completing Required Forms	-Screening-Pre ITP (New Process) -QOL -Discharge Day Checklist	RL Grubbs/Pam Johnson Kristi Fuller/Carline Robertson Tiffany Butler Sandy Taylor Jerome Greathouse
3:00-3:15	BREAK	
3:15-4:15	Waiver Application Process	Tom Underwood
4:15-5:00	Housing-Tools	Jerome Greathouse

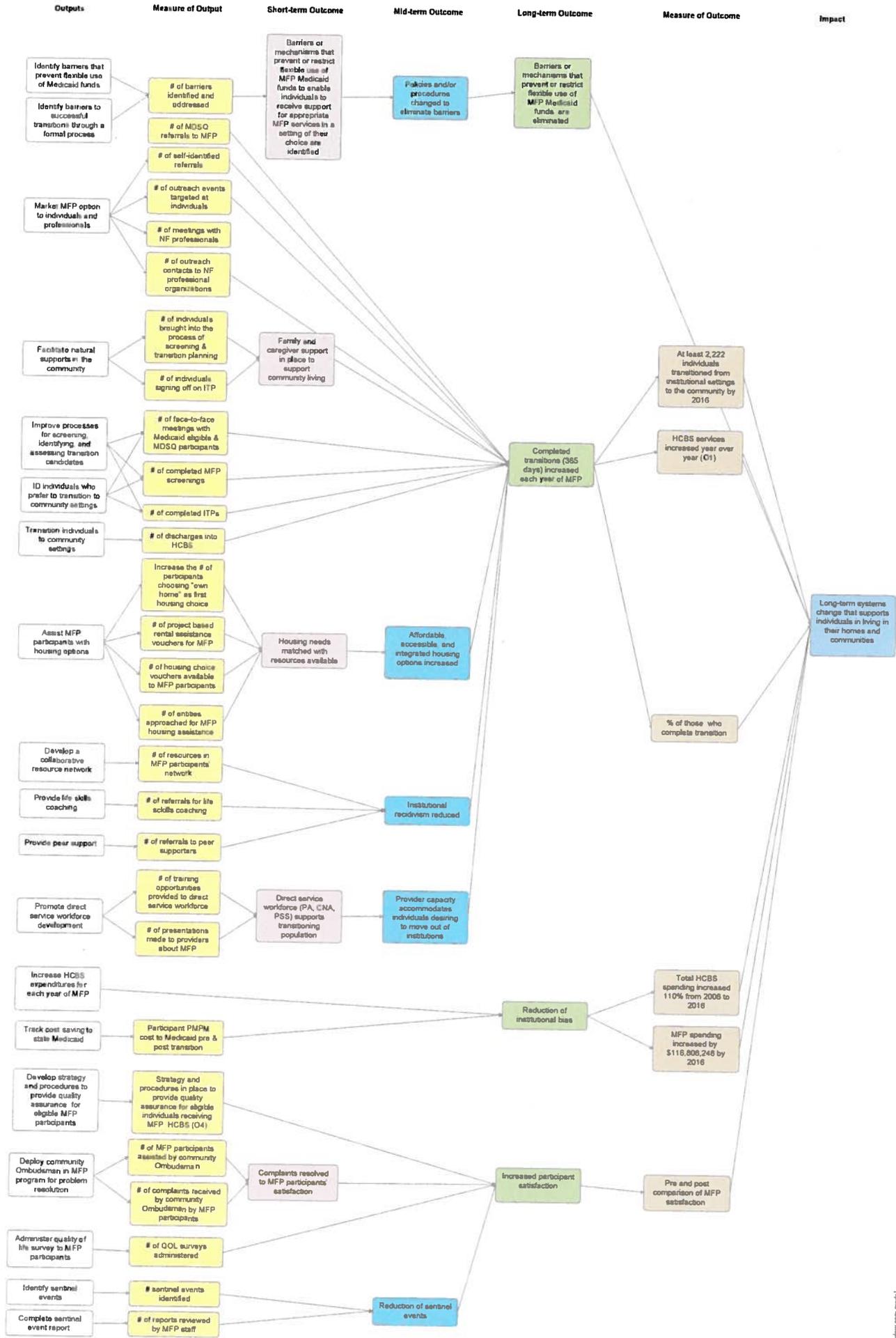
Day Two

Time	Topic	Presenter
8:30 Welcome	Introductions	Pam Johnson
8:45-10:15	Post ITP	RL and Pam
10:15 BREAK	BREAK	
10:30-Noon	-New Demonstration Services -Vendor Payments	RL Grubbs JW Wright Sandy and Jacqueline Whyte

LUNCH – “Family Conflict Management”-

1:00-2:30	-Home Care Ombudsman -Supportive Employment	DAS/DCH Doug Crandell
2:30-2:45	BREAK	
2:45-3:45	Q/A/Open Discussion	
3:45-4:45	-Reporting-	Leslie Vaughns
4:45-Closing		

Completion of Evaluation Forms – “ongoing following each session”





MFP QUALITY OF LIFE SURVEY

Presented to: DCH MFP Training
February 4, 2013



ANDREW YOUNG SCHOOL
OF POLICY STUDIES

GHPC ROLE

- Evaluation of the MFP program for DCH
 - Conduct analyses of the survey data and MFP service expenditures
 - Complete surveys at 1st & 2nd year follow-up
 - Co-facilitate the MFP Evaluation Team
 - Develop and revise the logic model

MATHEMATICA GUIDANCE

FAQ Document

- How soon is too soon to conduct the QoL survey (baseline)?
Although we originally recommended 2 weeks before transition, the motto now is “better earlier than after transition.” Mathematica’s Therefore, please find ways that work with your transition processes to conduct the baseline interview before people transition to the community, even if that means conducting the interview a month or more before transition.
- If a participant can’t communicate a response or a proxy doesn’t know well enough how to respond should we leave it blank or choose “don’t know”
 - Choose “don’t know.”
- Entering the Medicaid ID correctly is **EXTREMELY** important. Another reason to check the quality of your data entry.
- Ask questions as written (the manual has suggestions for ways to probe further if a respondent does not seem to understand the question).

MATHEMATICA GUIDANCE

Guidance on QoL Questions

- CMS/MPR guidance for conducting the QoL survey is provided: In general, CMS/MPR prefers that all QoL Survey questions get answered (even if with a "Don't Know"), don't leave questions blank.
- Questions 24-26a, which are listed as optional on the survey tool, are not to be completed as they were not approved by the GSU IRB. These questions are the exception to the above statement and should be left blank when inputting the responses into the database.

Guidance for QoL survey questions Q10, Q11, Q18 and Q19

- Q10) Question about food choice - how to answer Q10 for an MFP participant who is on a feeding tube. The appropriate answer would seem to be N/A, though that is not a possibility. Is 'No' the next best answer because the person has no choice?
- CMS/MPR responds - Q10 should be answered as "No" since the MFP participant didn't have a food choice.
- Q11) Phone access question) - how to answer Q11 for an MFP participant who is non-verbal. The answers are yes or no. Should this question be left blank as neither response is appropriate?
CMS/MPR responds - Q11 should be a "Don't Know" as phone access has not been a relevant part of this person's life right now and thus he or she wouldn't know.
- Q18) Bathroom access question - how to answer Q18 for an MFP participant who is incontinent. Should we leave this one blank?
CMS/MPR responds - Q18 should also be a "Don't Know" since this question doesn't really apply to the participant's situation and thus he or she wouldn't know.
- Q19) Have you ever talked with a case manager or support coordinator about any special equipment or changes to your home that might make your life easier? How to answer when someone says, "No, but he doesn't need any equipment or changes."
CMS/MPR responds - Put N/A as the person doesn't need any equipment or changes and thus the question is non-applicable

MPRID: 169210000045

42. Those are all the questions I have for you now. We would like to talk with you in about a year or so to find out how you are doing. In case we have trouble reaching you, what is the name, address, and phone number of a close relative or friend who is not living with you and is likely to know your location in the future? For example, a mother, father, brother, sister, aunt, uncle, or close friend.

No Contact Available
 Contact Available [Go to Question 43](#)

Contact Name: _____
Contact Street Address: _____
Contact City: _____
Contact State: _____
Contact Zip: _____
Contact Phone: _____

43. Interviewer: Did you complete the interview with the sample member alone, the sample member who was assisted by another, or with a proxy?

Sample Member Alone
 Sample Member with Assistance
 Proxy

44. Interviewer: Record date the interview was completed.

_____/_____/2011
Month Day Year

Notes: _____

[Go to Page 16](#) [Go to Page 17](#) [Go to Page 18](#) Jump to page:

Contact Information for the follow-up identified here

Identify a person who will (hopefully) always be in contact with the participant

Put the relationship of the contact in parentheses after their name

Additional contacts can be listed in the notes box

QUESTIONS?

Contact: Kristi Fuller
Telephone: 404-413-0292
Email: kwfuller@gsu.edu

Georgia Department of Community Health

Understand & Apply MFP Eligibility Criteria



Presentation to MFP Process Orientation Workshop
Presented by DCH

July 24/13

Georgia Department of Community Health

Mission

The Georgia Department of Community Health
We will provide Georgians with access to
affordable, quality health care through
effective planning, purchasing and oversight

We are dedicated to A Healthy Georgia.

Understand & Apply MFP Eligibility Criteria

- Referrals

Georgia Department of Community Health

2

Understand & Apply MFP Eligibility Criteria

- **Denials - determined ineligible for MFP because:**

- You have not resided in an inpatient facility (hospital, nursing facility, ICF) for at least 90 consecutive days; short-term rehabilitative stays do not count.
- 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 did not transition into a qualified residence.
- You did not cooperate in the transition planning process (describe process/steps and non-participation): _____



3

Understand & Apply MFP Eligibility Criteria

- **Terminations - determined no longer eligible because:**

- You are no longer receiving Medicaid benefits.
- You have moved to a non-qualified residence.
- You no longer meet institutional level of care criteria.
- You have informed us that you no longer wish to participate in MFP.
- You have moved outside of the service area for the State of Georgia.
- You have been readmitted to an inpatient facility for a period of six (6) months or more.



4


Dignity of Risk and Centers for Independent Living



Presentation to: MFP Process Orientation Workshop
 Presented by: Dawn Alford, NWGA CIL

Date: 2/21/13


Mission

The Georgia Department of Community Health
 We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

Dignity of Risk and Centers for Independent Living

- Dawn Alford**
 Northwest Georgia Center for Independent Living
 242 N. 5th Ave. SW
 Rome, GA 30165
 Phone: 706-314-0008
 Toll Free: 866-888-7845


2



The *Little* Things in Life



Choice of when and what to eat

Choice of what to wear

Choice to call or visit friends and family

Choice of place of worship

Choice of temperature control

Choice of recreation

Choice to have privacy and security of possessions

Choice of when to shower and/or take a bath

Choice of uninterrupted sleep when you want it

Choice of roommate

Centers for Independent Living (CILs) FAQ

What is a CIL (pronounced SIL)?

"The term 'center for independent living' means a consumer controlled, community-based, cross-disability, non-residential, private nonprofit agency that—
A.) is designed and operated within a local community by individuals with disabilities; and
B.) provides an array of independent living services." – 29 U.S.C. § 796a(1)

What are the basic tenets of independent living philosophy on which CILs operate?

Consumer control – decision-making, service delivery, management, and establishment of the policy and direction of the center. Individuals with disabilities must comprise at least 51% of the governing board AND staff.

Cross-disability – equal access to services regardless of type of disability or age

Self-help and self-advocacy – empowering others to achieve their goals; not "do for".

Peer role models – foundation on which services are provided

What are the four Core IL Services offered by ALL CILs?

Peer support/mentoring – a person with a disability (peer) who supports another person with a disability (consumer) to achieve his/her goals by mentoring, teaching, and sharing strategies and life experience.

Information and Referral – regarding disability-related rights and resources

Advocacy – individual and systems change

Independent Living Skills – to teach the skills necessary to take control of one's life

Do CILs provide other services besides the four Core IL Services?

Depending on the needs of the communities they serve and available funding, CILs may provide other services that vary from one center to another. Some examples of other services may include:

Nursing Facility Transition and Diversion – "5 th Core Service"	Youth Programs	Home Modifications
Refurbished Durable Medical Equipment Program (Touch the Future)	Refurbished Computers (ReBoot)	Caring Closet (Incontinence items for those with dementia/Alzheimer's)

Where can I find the CIL that serves my area?

In Georgia: <http://www.silcga.org/resources/find-cil-locations-in-georgia>

Other states: <http://www.ilru.org/html/publications/directory/index.html>

Where can I learn more about CILs and the independent living movement?

Statewide Independent Living Council of Georgia (SILC) – <http://www.silcga.org/>

National Council on Independent Living (NCIL) – <http://www.ncil.org/>

Independent Living Research Utilization (ILRU) – <http://www.ilru.org/>

NWGA Center for Independent Living

Formerly disABILITY LINK NW

242 N 5th Ave. SW

Rome, GA 30165-2851

Phone 706.314.0008

Toll Free 866.888.7845

"Like" us on Facebook at <https://www.facebook.com/NWGACIL>

History of Independent Living

By Gina McDonald and Mike Oxford

This account of the history of independent living stems from a philosophy which states that people with disabilities should have the same civil rights, options, and control over choices in their own lives as do people without disabilities.

The history of independent living is closely tied to the civil rights struggles of the 1950s and 1960s among African Americans. Basic issues--disgraceful treatment based on bigotry and erroneous stereotypes in housing, education, transportation, and employment--and the strategies and tactics are very similar. This history and its driving philosophy also have much in common with other political and social movements of the country in the late 1960s and early 1970s. There were at least five movements that influenced the disability rights movement.

Social Movements

The first social movement was deinstitutionalization, an attempt to move people, primarily those with developmental disabilities, out of institutions and back into their home communities. This movement was led by providers and parents of people with developmental disabilities and was based on the principle of "normalization" developed by Wolf Wolfensberger, a sociologist from Canada. His theory was that people with developmental disabilities should live in the most "normal" setting possible if they were expected to behave "normally." Other changes occurred in nursing homes where young people with many types of disabilities were warehoused for lack of "better" alternatives (Wolfensberger, 1972).

The next movement to influence disability rights was the civil rights movement. Although people with disabilities were not included as a protected class under the Civil Rights Act, it was a reality that people could achieve rights, at least in law, as a class. Watching the courage of Rosa Parks as she defiantly rode in the front of a public bus, people with disabilities realized the more immediate challenge of even getting on the bus.

The "self-help" movement, which really began in the 1950s with the founding of Alcoholics Anonymous, came into its own in the 1970s. Many self-help books were published and support groups flourished. Self-help and peer support are recognized as key points in independent living philosophy. According to this tenet, people with similar disabilities are believed to be more likely to assist and to understand each other than individuals who do not share experience with similar disability.

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Demedicalization was a movement that began to look at more holistic approaches to health care. There was a move toward "demystification" of the medical community. Thus, another cornerstone of independent living philosophy became the shift away from the authoritarian medical model to a paradigm of individual empowerment and responsibility for defining and meeting one's own needs.

Consumerism, the last movement to be described here, was one in which consumers began to question product reliability and price. Ralph Nader was the most outspoken advocate for this movement, and his staff and followers came to be known as "Nader's Raiders." Perhaps most fundamental to independent living philosophy today is the idea of control by consumers of goods and services over the choices and options available to them.

The independent living paradigm, developed by Gerben DeJong in the late 1970s (DeJong, 1979), proposed a shift from the medical model to the independent living model. As with the movements described above, this theory located problems or "deficiencies" in the society, not the individual. People with disabilities no longer saw themselves as broken or sick, certainly not in need of repair. Issues such as social and attitudinal barriers were the real problems facing people with disabilities. The answers were to be found in changing and "fixing" society, not people with disabilities. Most important, decisions must be made by the individual, not by the medical or rehabilitation professional.

Using these principles, people began to view themselves as powerful and self-directed as opposed to passive victims, objects of charity, cripples, or not-whole. Disability began to be seen as a natural, not uncommon, experience in life; not a tragedy.

Independent Living

Ed Roberts is considered to be the "father of independent living." Ed became disabled at the age of fourteen as a result of polio. After a period of denial in which he almost starved himself to death, Ed returned to school and received his high school diploma. He then wanted to go to college. The California Department of Rehabilitation initially rejected Ed's application for financial assistance because it was decided that he was "too disabled to work." He went public with his fight and within one week of doing so, was approved for financial aid by the state. Fifteen years after Ed's initial rejection by the State of California as an individual who was "too" disabled, he became head of the California Department of Rehabilitation--the agency that had once written him off.

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After Ed earned his associate's degree at the College of San Mateo, he applied for admission to the University of California at Berkeley. After initial resistance on the part of the university, Ed was accepted. The university let him use the campus hospital as his dormitory because there was no accessible student housing (none of the residential buildings could support the weight of Ed's 800-lb. iron lung). He received attendant services through a state program called "Aid to the Totally Disabled." This is a very important note because this was consumer-controlled personal assistance service. The attendants were hired, trained, and fired by Ed.

In 1970, Ed and other students with disabilities founded a disabled students' program on the Berkeley campus. His group was called the "Rolling Quads." Upon graduation, the "Quads" set their sights on the need for access beyond the University's walls.

Ed contacted Judy Heumann, another disability activist, in New York. He encouraged her to come to California and along with other advocates; they started the first center for independent living in Berkeley. Although it started out as a "modest" apartment, it became the model for every such center in the country today. This new program rejected the medical model and focused on consumerism, peer support, advocacy for change, and independent living skills training.

In 1983, Ed, Judy, and Joan Leon, co-founded the World Institute on Disability (WID), an advocacy and research center promoting the rights of people with disabilities around the world. Ed Roberts died unexpectedly on March 14, 1995.

The early 1970s was a time of awakening for the disability rights movement in a related, but different way. As Ed Roberts and others were fighting for the rights of people with disabilities presumed to be forever "homebound" and were working to assure that participation in society, in school, in work, and at play was a realistic, proper, and achievable goal, others were coming to see how destructive and wrong the systematic institutionalization of people with disabilities could be. Inhuman and degrading treatment of people in state hospitals, schools and other residential institutions such as nursing facilities were coming to light and the financial and social costs were beginning to be considered unacceptable. This awakening within the independent living movement was exemplified by another leading disability rights activist, Wade Blank.

ADAPT

Wade Blank began his lifelong struggle in civil rights activism with Dr. Martin Luther King, Jr. to Selma, Alabama. It was during this period that he learned

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about the stark oppression which occurred against people considered to be outside the “mainstream” of our “civilized” society. By 1971, Wade was working in a nursing facility, Heritage House, trying to improve the quality of life of some of the younger residents. These efforts, including taking some of the residents to a Grateful Dead concert, ultimately failed. Institutional services and living arrangements were at odds with the pursuit of personal liberties and life with dignity.

In 1974, Wade founded the Atlantis Community, a model for community-based, consumer-controlled, independent living. The Atlantis Community provided personal assistance services primarily under the control of the consumer within a community setting. The first consumers of the Atlantis Community were some of the young residents “freed” from Heritage House by Wade (after he had been fired). Initially, Wade provided personal assistance services to nine people by himself for no pay so that these individuals could integrate into society and live lives of liberty and dignity.

In 1978, Wade and Atlantis realized that access to public transportation was a necessity if people with disabilities were to live independently in the community. This was the year that American Disabled for Accessible Public Transit (ADAPT) was founded.

On July 5-6, 1978, Wade and nineteen disabled activists held a public transit bus “hostage” on the corner of Broadway and Colfax in Denver, Colorado. ADAPT eventually mushroomed into the nation’s first grassroots, disability rights, activist organization.

In the spring of 1990, the Secretary of Transportation, Sam Skinner, finally issued regulations mandating lifts on buses. These regulations implemented a law passed in 1970—the Urban Mass Transit Act—which required lifts on new buses. The transit industry had successfully blocked implementation of this part of the law for twenty years, until ADAPT changed their minds and the minds of the nation.

In 1990, after passage of the Americans With Disabilities Act (ADA), ADAPT shifted its vision toward a national system of community-based personal assistance services and the end of the apartheid-type system of segregating people with disabilities by imprisoning them in institutions against their will. The acronym ADAPT became “American Disabled for Attendant Programs Today.” The fight for a national policy of attendant services and the end of institutionalization continues to this day.

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Wade Blank died on February 15, 1993, while unsuccessfully attempting to rescue his son from drowning in the ocean. Wade and Ed Roberts live on in many hearts and in the continuing struggle for the rights of people with disabilities. The lives of these two leaders in the disability rights movement, Ed Roberts and Wade Blank, provide poignant examples of the modern history, philosophy, and evolution of independent living in the United States. To complete this rough sketch of the history of independent living, a look must be taken at the various pieces of legislation concerning the rights of people with disabilities, with a particular emphasis on the original "bible" of civil rights for people with disabilities, the Rehabilitation Act of 1973.

Civil Rights Laws

Before turning to the Rehabilitation Act, a chronological listing and brief description of important federal civil rights laws affecting people with disabilities is in order.

- 1964--Civil Rights Act: prohibits discrimination on the basis of race, religion, ethnicity, national origin, and creed; later, gender was added as a protected class.
- 1968--Architectural Barriers Act: prohibits architectural barriers in all federally owned or leased buildings.
- 1970--Urban Mass Transit Act: requires that all new mass transit vehicles be equipped with wheelchair lifts. As mentioned earlier, it was twenty years, primarily because of machinations of the American Public Transit Association (APTA), before the part of the law requiring wheelchair lifts was implemented.
- 1973--Rehabilitation Act: particularly Title V, Sections 501, 503, and 504, prohibits discrimination in federal programs and services and all other programs or services receiving federal funding.
- 1975--Developmental Disabilities Bill of Rights Act: among other things, establishes Protection and Advocacy services (P & A).
- 1975--Education of All Handicapped Children Act (PL 94-142): requires free, appropriate public education in the least restrictive environment possible for children with disabilities. This law is now called the Individuals with Disabilities Education Act (IDEA).
- 1978--Amendments to the Rehabilitation Act: provides for consumer-controlled

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centers for independent living.

1983--Amendments to the Rehabilitation Act: provides for the Client Assistance Program (CAP), an advocacy program for consumers of rehabilitation and independent living services.

1985--Mental Illness Bill of Rights Act: requires protection and advocacy services (P & A) for people with mental illness.

1988--Civil Rights Restoration Act: counteracts bad case law by clarifying Congress' original intention that under the Rehabilitation Act, discrimination in ANY program or service that is a part of an entity receiving federal funding--not just the part which actually and directly receives the funding--is illegal.

1988--Air Carrier Access Act: prohibits discrimination on the basis of disability in air travel and provides for equal access to air transportation services.

1988--Fair Housing Amendments Act: prohibits discrimination in housing against people with disabilities and families with children. Also provides for architectural accessibility of certain new housing units, renovation of existing units, and accessibility modifications at the renter's expense.

1990--Americans with Disabilities Act: provides comprehensive civil rights protection for people with disabilities; closely modeled after the Civil Rights Act and the Section 504 of Title V of the Rehabilitation Act and its regulations.

The modern history of civil rights for people with disabilities is three decades old. A key piece of this decades-long process is the story of how the Rehabilitation Act of 1973 was finally passed and then implemented. It is the story of the first organized disability rights protest.

The Rehabilitation Act of 1973

In 1972, Congress passed a rehabilitation bill that independent living activists cheered. President Richard Nixon's veto prevented this bill from becoming law. During the era of political activity at the end of the Vietnam War, Nixon's veto was not taken lying down by disability activists who launched fierce protests across the country. In New York City, early leader for disability rights, Judy Heumann, staged a sit-in on Madison Avenue with eighty other activists. Traffic was stopped. After a flood of angry letters and protests, in September 1973, Congress overrode Nixon's veto and the Rehabilitation Act of 1973 finally

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became law. Passage of this pivotal law was the beginning of the ongoing fight for implementation and revision of the law according to the vision of independent living advocates and disability rights activists.

Key language in the Rehabilitation Act, found in Section 504 of Title V, states that:

No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Advocates realized that this new law would need regulations in order to be implemented and enforced. By 1977, Presidents Nixon and Ford had come and gone. Jimmy Carter had become president and had appointed Joseph Califano his Secretary of Health, Education and Welfare (HEW). Califano refused to issue regulations and was given an ultimatum and deadline of April 4, 1977. April 4 went by with no regulations and no word from Califano.

On April 5, demonstrations by people with disabilities took place in ten cities across the country. By the end of the day, demonstrations in nine cities were over. In one city—San Francisco—protesters refused to disband.

Demonstrators, more than 150 people with disabilities, had taken over the federal office building and refused to leave. They stayed until May 1. Califano had issued regulations by April 28, but the protesters stayed until they had reviewed the regulations and approved of them.

The lesson is a fairly simple one. As Martin Luther King said,

It is an historical fact that the privileged groups seldom give up their privileges voluntarily. Individuals may see the moral light and voluntarily give up their unjust posture, but, as we are reminded, groups tend to be more immoral than individuals. We know, through painful experience that freedom is never voluntarily given by the oppressor, it must be demanded by the oppressed.

Leaders in the Independent Living Movement

The history of the independent living movement is not complete without mention of some other leaders who continue to make substantial contributions to the movement and to the rights and empowerment of people with disabilities.

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History of Independent Living

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- Max Starkloff, Charlie Carr, and Marca Bristo founded the National Council on Independent Living (NCIL) in 1983. NCIL is one of the only national organizations that is consumer-controlled and promotes the rights and empowerment of people with disabilities.
- Justin Dart played a prominent role in the fight for passage of the Americans with Disabilities Act, and is seen by many as the spiritual leader of the movement today.
- Lex Frieden is co-founder of ILRU Program. As director of the National Council on Disability, he directed preparation of the original ADA legislation and its introduction in Congress.
- Liz Savage and Pat Wright are considered to be the "mothers of the ADA." They led the consumer fight for the passage of the ADA.

There are countless other people who have and continue to make substantial contributions to the independent living movement.

REFERENCES

DeJong, Gerben. Independent Living: From Social Movement to Analytic Paradigm. *Archives of Physical Medicine and Rehabilitation* 60, October 1979.

Wolfensberger, Wolf. *The Principle of Normalization in Human Services*. Toronto: National Institute on Mental Retardation, 1972.

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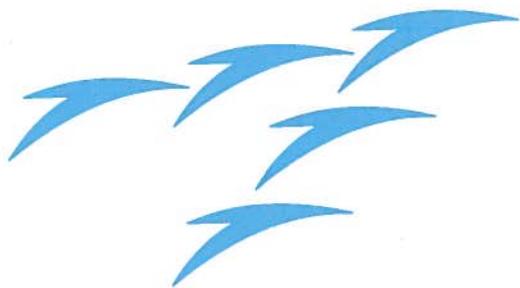
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DISABILITY ETIQUETTE:

ENGAGING PEOPLE WITH DISABILITIES

Don't let fear and uncertainty keep you from getting to know people with disabilities. Fear of the unknown and lack of knowledge about interacting can lead to uneasiness when meeting a person who has a disability.

Remember: a person with a disability is a person with feelings. Treat him or her as you would want to be treated, and then let common sense and friendship break down any barriers you may encounter.



T E N N E S S E E
D I S A B I L I T Y
C O A L I T I O N



INSIDE:

- Meeting a person with a disability
- Engaging a person who uses a wheelchair
- Meeting someone with a cognitive impairment
- And more ...

Meeting a person with a disability

1. **A handshake is NOT a standard greeting for everyone.** When in doubt, ASK the person whether he or she would like to shake hands with you. A smile along with a spoken greeting is always appropriate.
2. **Speak directly to the person with a disability,** not just to persons who may be accompanying him or her.
3. **Don't mention the person's disability,** unless he or she talks about it or it is relevant to the conversation.
4. **Treat adults as adults.** Don't patronize or talk down to people with disabilities. Likewise, don't lavish praise on a person with a disability for having the "courage" to overcome a disability.
5. **Be patient and give your undivided attention,** especially with someone who speaks slowly or with great effort.
6. **Never pretend to understand what a person is saying.** Ask the person to repeat or rephrase.
7. **It is okay to use common expressions** like "see you soon" or "I'd better be running along."
8. **Relax. We all make mistakes.** Offer an apology if you forget some courtesy. Keep a sense of humor and a willingness to communicate.

Interacting with a wheelchair user

1. **Personal space** – Do not push, lean on, or hold onto a person's wheelchair unless the person asks you to. The wheelchair is part of his or her personal space.
2. **Eye-to-Eye** – Try to put yourself at eye level when talking with someone in a wheelchair. Sit or kneel in front of the person.
3. **Clear a path** – Rearrange furniture or objects to accommodate a wheelchair before the person arrives.
4. **Know the geography** – If asked, know where someone can find accessible restrooms, telephones, and water fountains in the building.
5. **Directions** – When giving directions to a person in a wheelchair, consider distance, weather conditions, and physical obstacles (curbs, stairs, steep hills, etc.).



Meeting someone with a cognitive impairment that affects learning, intelligence, or brain function

1. **Keep your communication simple.** Use short sentences and rephrase comments or questions for better clarity.
2. **Stay on point** by focusing on one topic at a time.
3. **Allow the person time** to respond, ask questions and clarify your comments.
4. **Focus on the person** as he or she responds to you and pay attention to body language.
5. **Repetition.** If appropriate, repeat back any messages to confirm mutual understanding.



Engaging someone who is blind or has a disability that affects vision

1. **Greetings** – When meeting the person, identify yourself and introduce others who may be present.
2. **Departing** – Don't leave the person without excusing yourself first.
3. **Guiding** – When asked to guide someone, never push or pull the person. Offer your arm and allow him or her to reach for you, then walk slightly ahead. Point out doors, stairs, and curbs as you approach them.
4. **The landscape** – As you guide a person into a room, describe the layout, the location of furniture, and note who else is nearby.
5. **Details matter** – Be specific when describing the location of objects. (Example: "There is a chair three feet from you at eleven o'clock.")
6. **Guide dogs** – Don't pet or distract a guide dog. The dog is responsible for its owner's safety and is always working. It is not a pet.



Meeting a person with a disability that affects speech

1. **Pay attention, be patient, and wait** for the person to complete a word or thought. Do not finish it for the person.
2. **Ask the person to repeat what is said** if you do not understand. Tell the person what you heard and see if it is close to what he or she is saying.
3. **Be prepared for persons who use assistive technology** to enhance or augment speech. Don't be afraid to communicate with someone who uses an alphabet board or a computer to communicate.



Communicating with someone who is deaf or uses an assisted hearing device

1. **Let the person take the lead** in establishing the communication mode, such as lip-reading, sign language, or writing notes.
2. **Talk directly to the person** even when a sign language interpreter is present.
3. **If the person lip-reads**, face him or her directly, speak clearly and with a moderate pace.
4. **With some people** it may help to simplify your sentences and use more facial expressions and body language.



Service animals

1. **It takes all kinds** – Service animals come in all shapes and sizes. In addition to the traditional guide dog, a variety of dogs and other service animals may detect seizures before they occur, enhance therapies for children with autism, provide a calming presence for adults, or assist with a wide range of daily living activities.
2. **Engaging animal** – A service animal is a physical extension of a person with a disability and is there to work. It may be tempting to pet or call for a service animal's attention. However, for the safety and well-being of the team ask permission from the service animal's owner first.
3. **Questions** – The law varies widely so if you have a specific question, please contact the Tennessee Disability Coalition.



Using appropriate language

Life for most people with mental or physical disabilities has vastly improved over the past forty years. However, some things have been slow to change; namely, attitudes and perceptions about people with disabilities. The use of outdated language and words to describe people with disabilities contributes to perpetuating old stereotypes.

If public opinion about people with disabilities is to evolve, then awareness and usage of more appropriate language needs to become part of everyday discourse.

1. **Disability relevance** – Do not refer to a person's disability unless it is relevant to a situation or discussion.
2. **Disability vs. handicap** – The use of the word "handicap" is considered offensive, and the preferred term is "disability." Generally, it is only acceptable to use "handicap" when referring to accommodations such as handicap parking, although accessible parking is preferred today.
3. **People first language** – Say "person with a disability" rather than a "disabled person." This emphasizes that individuals with disabilities are people first and thus should not be defined by their disability.
4. **Referencing groups** – Avoid referring to a group of individuals as the disabled, quadriplegics, or the retarded. Instead, use references such as "persons with a disability," "persons with quadriplegia," and "persons with an intellectual disability." An exception involves people who are deaf and prefer the phrase "The Deaf."
5. **Negative and sensational descriptions** – Do not say "suffers from," "a victim of," "afflicted with," or "crippled." Never say "invalid." These portrayals elicit unwanted sympathy, or worse, pity toward individuals with disabilities.
6. **Gratuitous, but well-meaning praise** – Don't portray people with disabilities as overly courageous, brave, special, or superhuman because they have "overcome" a disability. Doing so implies that it is unusual for people with disabilities to have talents, skills, and the ability to contribute in society.
7. **Wheelchairs and adaptive technology** – Never say "wheelchair-bound" or "confined to a wheelchair." People use mobility or adaptive equipment as tools of greater independence.
8. **Presume competence** – Never assume that a person who looks or speaks differently has a cognitive disability.

TALKING ABOUT DISABILITY

The preferred "people first language" recognizes that someone is a person first, and that the disability is a part of, but not the whole person. However, some people with disabilities reject use of people first language. These guidelines have developed independently within distinct disability communities, and they may sometimes appear contradictory. For example, some persons with reduced vision find the term "visually-impaired" acceptable, but some persons with reduced hearing find the term "hearing-impaired" offensive and prefer "hard of hearing."

WORDS & PHRASES TO AVOID



PREFERRED ALTERNATIVES

a disabled person

the handicapped or the crippled

normal, healthy or
able-bodied person/people

wheelchair-bound or
confined to a wheelchair

birth defect or affliction

a victim of cerebral palsy
(or other condition)

suffers from polio, afflicted with
polio or post-polios

mentally retarded, a retard
slow or special

the Down's person or Mongoloid

the epileptic or epileptics
fits or epileptic fits

the mentally ill
crazy, psycho, nuts, mental case

the blind or blind as a bat

hearing-impaired
deaf-mute, deaf and dumb

person with a disability

person with a disability

people without disabilities
typical person

a wheelchair user
uses a wheelchair

congenital disability or birth anomaly

has cerebral palsy
has (insert condition)

has had polio, experienced polio
has a disability due to polio

person with an intellectual or
developmental disability

person with Down Syndrome

person with epilepsy
person with a seizure disorder
seizure or epileptic episode

people who have mental illness
person with a mental
or emotional disorder

people who are blind
or visually impaired

person who is hard of hearing
the Deaf, a person who is deaf

COMMON COURTESIES FOR ENGAGING PEOPLE WITH DISABILITIES

- 1. Personal Questions** – Avoid asking personal questions about someone's disability. If you must ask, be sensitive and show respect. Do not probe if the person declines to discuss it.
- 2. Patience** – It may take extra time for a person with a disability to do or say something.
- 3. Offering Assistance** – Be polite and friendly when offering assistance and wait until your offer is accepted. Listen or ask for specific instructions.
- 4. Meetings & Events** – Create an environment that is welcoming to everyone. Anticipate specific accommodations that a person with a disability or group might need and contact them for information on how to best meet their needs.

ABOUT THE TENNESSEE DISABILITY COALITION

The Coalition is an alliance of organizations and individuals who have joined to promote the full and equal participation of men, women and children with disabilities in all aspects of life. We work together to advocate for public policy that ensures self-determination, independence, empowerment, and inclusion for people with disabilities in areas such as accessibility, education, health care, housing, and voting rights.

Organizational Membership – If your organization would like to join the Coalition, then please give us a call at the phone number below or contact our Executive Director at coalition@tndisability.org

Individual Membership – If you would like to join the Coalition as a member of our Disability Action Network, please give us a call at the phone number below or contact a member of our Public Policy Team at news@tndisability.org.



TENNESSEE DISABILITY COALITION
955 Woodland Street • Nashville, TN 37206

Phone: 615.383.9442 • Fax: 615.383.1176 • On the web: www.tndisability.org

Georgia Department of Community Health

MFP Screening and Pre-Discharge Planning Using the Pre-ITP



Presentation to: MFP Process Orientation Workshop
Presented by: Pam Johnson and RL Grubbs

DATE: 2/4/15

Georgia Department of Community Health

Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

Changes to the MFP Screening

- **Demographics Changes**
 - Ethnicity and Race
 - MFP Target Population
 - Primary Disability
 - Referral Source
 - Waiver Referral
 - Refused/Ineligible
 - Primary Language or Deaf/HoH

Georgia Department of Community Health

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Changes to the MFP Screening

- **Personal Data** – no changes
- **Background Data** – questions will indicated circle of support/network to call on
- **Housing Section** –
 - ask Q15 and then code
 - Ask Q21 and then code
 - Ask Q22 for housing focus/development initiative
 - Ask Q23 to identify possible roommate situation


3

Changes to the MFP Screening

- **Waiver Service History** –
 - Importance for waiver referral
 - Cover waiver options using HCBS booklet
- **Health Care Needs**
 - Ask Q27, enter and then code response
 - Prepare to assist/make referrals based on responses to Q28, 29, 30, 31 and 32


4

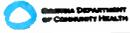
Pre-Discharge Transition Planning (Pre-ITP)

- **Why ITP has two versions** – Pre-ITP and Post-ITP
- **Housing Choice/Living Arrangement**
 - Ask Q3 and code based on MFP housing type and indicate if housing choice is needed.
 - If Yes, describe problem/solution.
 - If No, move on to Q4
- **Health and Nutrition Goals**
 - Goals From Person Centered Planning
 - Address issues from Screening (Q27 – 31)


5

Pre-Discharge Transition Planning (Pre-ITP)

- **24/7 Emergency Backup Plans**
 - Essential function of MFP
 - must be tested on Discharge day
- **Other Issues (unique and necessary to transition)**
 - Goals From Person Centered Planning
 - Examples –
- **Scenarios – Small Groups convene, conduct screening, PCP and complete Pre-ITP and report**



6

SCENARIO: Melinda

(Name has been changed)

Melinda is a 57 year old who is legally blind and has cerebral palsy. She uses a manual wheelchair. She has lived in the nursing home for 27 years. She lived with her mother who had a severe stroke. After her mother's stroke, they were then forced to move to a nursing home to be able to stay together. Melinda's mother died while they were in the nursing home and she doesn't have any other family members to care for her, so she ended up having to stay in the nursing home. Melinda wants to transition out into her own home so that she can drink her hot tea when she wants it and can eat the foods she likes to eat. Disability Connections (the Center for Independent Living in Macon) began working with Melinda to transition her into the community. She has applied for the Independent Care Waiver Program, but has not heard back from GMCF. Housing for Melinda will need to be wheelchair accessible.



As a group, your task is to –

- Select a member to 'play' Melinda
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on your group's discussion
- Use Person Centered Planning techniques to identify and develop short and long term goals
- Complete the MFP Screening and Pre-ITP

At a minimum, your group must address and plan for the following issues -

- Background
- Housing needed/ Housing Choice/Living Arrangements
- Waiver referral
- Financial Data
- Health and Nutrition
- 24/7 Emergency Backup Plans
- Other issues unique to the participant and necessary for discharge (environmental modifications, transportation, referrals for Durable Medical Equipment (DME), etc. that are needed to transition

Once your group has completed the Screening and Pre-ITP, the facilitator leads the group in a discussion of the following questions –

- How did we apply Person-Centered Planning?
- What were the essential things needed to transition successfully to the community and were these written up in the Pre-ITP?
- The note-taker/reporter will be asked to report the group's answers to these questions.

SCENARIO: Gary

(Name has been changed)

Gary has been in the nursing home for the last seven years. He was shot during an altercation. The gunshot wound left him paralyzed from the neck down (quadriplegic). His right leg is amputated below the knee. His speech is affected. He can speak but in very low volume. While it is difficult to understand him, it becomes somewhat easier with repetition. He has a manual chair which he cannot operate independently. He seems easy to get along with but is very particular about things. He smokes with the assistance of nursing home staff lighting and placing the cigarette in his mouth. It has been reported from the nursing home that he can get quite upset and will resort to biting and/or spitting NH staff. He has stated that he wants to get out of the nursing home and get his own place.



As a group, your task is to –

- Select a member to ‘play’ Gary
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on your group’s discussion
- Use Person Centered Planning techniques to identify and develop short and long term goals
- Complete the MFP Screening and Pre-ITP

At a minimum, your group must address and plan for the following issues -

- Background
- Housing needed/ Housing Choice/Living Arrangements
- Waiver referral
- Financial Data
- Health and Nutrition
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- How did we apply Person-Centered Planning?
- What were the essential things needed to transition successfully to the community and were these written up in the Pre-ITP?

The note-taker/reporter will be asked to report the group’s answers to these questions.

SCENARIO: Sandra

(Name has been changed)

Sandra is a 35 year old lady who has cerebral palsy. She has very limited use of her lower extremities and limited use of her arms and hands. She needs assistance with almost all Activities of Daily Living, although she does not know to ask for this assistance. She can be understood when speaking, if you are patient and do not interrupt her train of thought. She does have trouble with some reading, math and reasoning/critical thinking skills. She does not have a high school diploma. She has a power wheelchair that does not work and is using a manual chair. She does not drive nor own a car. She has requested to visit someone who has already transitioned into the community from a nursing home to see how they are doing things. Sandra has been in the nursing home for 15 years. When her mother passed away, her step father put her in a nursing home. She is her own guardian, but has never lived out on her own. She is open to moving out of the rural county where she now lives to a larger metro area where public transportation and housing may be available.



As a group, your task is to –

- Select a member to 'play' Sandra
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on your group's discussion
- Use Person Centered Planning techniques to identify and develop short and long term goals
- Complete the MFP Screening and Pre-ITP

At a minimum, your group must address and plan for the following issues -

- Background
- Housing needed/ Housing Choice/Living Arrangements
- Waiver referral
- Financial Data
- Health and Nutrition
- 24/7 Emergency Backup Plans
- Other issues unique to the participant and necessary for discharge (environmental modifications, transportation, referrals for Durable Medical Equipment (DME), etc. that are needed to transition

Once your group has completed the Screening and Pre-ITP, the facilitator leads the group in a discussion of the following questions –

- How did we apply Person-Centered Planning?
- What were the essential things needed to transition successfully to the community and were these written up in the Pre-ITP?
- The note-taker/reporter will be asked to report the group's answers to these questions.

SCENARIO: Joseph

(Name and picture has been changed)

Joseph is a 45 year old man with severe diabetes. He tried to kill himself and ended up partially paralyzed. He uses a manual wheelchair and propelled his chair with his feet. He arms are contracted and his feet are in bad condition due to his diabetes and propelling his wheelchair. Joseph has lived in the nursing home for 5 years and his only family contact is with his aging grandmother. Joseph communicates verbally; he speaks slowly and with difficulty. He does not drive nor own a car



As a group, your task is to –

- Select a member to 'play' Joseph
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on your group's discussion
- Use Person Centered Planning techniques to identify and develop short and long term goals
- Complete the MFP Screening and Pre-ITP

At a minimum, your group must address and plan for the following issues -

- Background
- Housing needed/ Housing Choice/Living Arrangements
- Waiver referral
- Financial Data
- Health and Nutrition
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Once your group has completed the Screening and Pre-ITP, the facilitator leads the group in a discussion of the following questions –

- How did we apply Person-Centered Planning?
- What were the essential things needed to transition successfully to the community and were these written up in the Pre-ITP?

The note-taker/reporter will be asked to report the group's answers to these questions.

SCENARIO: Bill

(Name and picture have been changed)

Bill is a 61 year old man who had a severe stroke which left him partially paralyzed on his right side and unable to communicate clearly. His speech is severely affected and a word or two maybe understood verbally. The stroke has prevented him from speaking the words he knows. He uses a manual wheelchair and propels with his left hand and left foot. After his stroke, he went into the nursing home for rehabilitation and never left. His family provides no support for him. He does not drive nor own a car.



As a group, your task is to –

- Select a member to 'play' Bill
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on your group's discussion
- Use Person Centered Planning techniques to identify and develop short and long term goals
- Complete the MFP Screening and Pre-ITP

At a minimum, your group must address and plan for the following issues -

- Background
- Housing needed/ Housing Choice/Living Arrangements
- Waiver referral
- Financial Data
- Health and Nutrition
- 24/7 Emergency Backup Plans
- Other issues unique to the participant and necessary for discharge (environmental modifications, transportation, referrals for Durable Medical Equipment (DME), etc. that are needed to transition

Once your group has completed the Screening and Pre-ITP, the facilitator leads the group in a discussion of the following questions –

- How did we apply Person-Centered Planning?
- What were the essential things needed to transition successfully to the community and were these written up in the Pre-ITP?

The note-taker/reporter will be asked to report the group's answers to these questions.



MFP Quality of Life Survey



Presentation to: 2013 MFP Process Orientation Workshop

Presented by: Carline Robertson, DHS DAS/MFP



Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

Money Follows the Person (MFP)

Quality of Life Survey

- The Quality of Life survey is administered to all Money Follows the Person participants in every state participating in the Money Follows the Person initiative.
- The Quality of Life survey is conducted to help CMS and DCH/MFP understand the perspectives and experiences of MFP participants as they resettle in the community.

Quality of Life Survey Measures Seven Domains Separated into Modules

- Module 1: Living Situation
- Module 2: Choice and Control
- Module 3: Access to Personal Care
- Module 4: Respect and Dignity
- Module 5: Community Integration and Inclusion
- Module 6: Satisfaction
- Module 7: Health Status

Target Population is MFP participants transitioning from institutionalized care.

The survey is administered to participants at three points in time.

- 30 days to 2 weeks before discharge or no more than 10 days after discharge from the nursing facility (completed by TC)
- 11 months after transition (completed by GHPC)
- 24 months after transition (completed by GHPC)
- The QOL raw data file is exported to an Excel spreadsheet and sent to DAS point of contact.
- Baseline Quality of Life interviews conducted after the transition to the community should be extremely rare and missed baseline Quality of Life interviews should not occur.

Questions

- If you have questions, please feel free to contact Carline Robertson or JW Wright.
- In addition, QOL analysis can be found on the DCH website.
- Carline Robertson at 404-657-2429
- JW Wright at 404-657-8756


 GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 Quality of Life Survey



Presentation to: MFP Process Orientation Workshop
 Presented by: Tiffany Butler, MSW, DD Coordinator

Page 2 of 3


 GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 Mission

The Georgia Department of Community Health
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Quality of Life Survey
 

- Administration of survey**
 - Baseline: In person, after being accepted into program, 14-30 days prior to discharge.
 - First year follow-up
 - Second year follow-up
- Modules covered**
 - Living situation -Choice and Control -Access to Personal Care
 - Respect & Dignity -Community Integration -Satisfaction -Health Status
- Respondents**
 - Sample member alone -Sample member w/assistance -Proxy
- Non-Applicable Questions**
 - Phone/Bathroom/TV- "Don't Know"
 - Food Choice- "No"


 GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2

Quality of Life Survey

Key Take-away points:

- Always include respondent/participant in interview.
- Capture the participant's voice.
- Work with transition team/process to schedule QoL.
- Ask questions as written; conduct survey same way, every time.



3

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

MFP 2013 Process Orientation Workshop



Presented by Sandy Taylor

Date: 2-4-13

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Mission

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Discharge Day Checklist

- New Additions
 - MFP Target Population
 - Housing Subsidy
- Housing Types
 - Lives with Family – check box for yes
- 24/7 Emergency Back Up
- Home Visits
- QOL Survey



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2

Contact Information

Sandy Taylor, Program Specialist
2 Peachtree Street NW, 37th Floor
Atlanta, GA 30303
Phone: 404-656-0729
Fax No.: 770-344-4060
staylor@dch.ga.gov



Georgia Department
of Community Health

3

 **Medicaid Waiver Options
for MFP Transitions**



Presentation to MFP Process Orientation Workshop
Presented by Tom Unkrinwood, CCSP Program Specialist, Medicaid Division, DCH

Page | January 4, 2013

Your Mission

- **Get NH resident back to the community with home based services and NO BREAK in Medicaid eligibility!!!**



"HCBS" Waiver Programs

- **Community Care Services Program (CCSP)**
- **Service Options Using Resources in Community Environments (SOURCE)**
- **Independent Care Waiver Program (ICWP)**



HCBS Waiver Programs

- New Options (NOW) Waiver
- Comprehensive Support Services (COMP) Waiver
- GA Pediatric Program (GAPP).

CCSP

- Serves elderly and disabled
- Administered by Division of Aging Services (DAS)
- Application through ADRC inquiry
- Assessment within 5 days by RN
- Care coordination through AAA

SOURCE

- Serves elderly and disabled on SSI
- Medicaid eligibility already established
- Care coordination through SOURCE care management agencies
- Includes primary care case management

CCSP/SOURCE Services

- Adult Day Health Services (ADH)
- Alternative Living Services (ALS)
- Emergency Response Services (ERS)
- Home Delivered Meals (HDM)
- Home Delivered Services (HDS)
- Personal Support Services (PSS)
- Primary Care Case Management (PCCM)
(SOURCE Only)

ICWP

- Serves severely physically disabled 18-64
- Also serves adults with TBI
- Application and assessment through GA Medical Care Foundation (GMCF)
- Case Management through private contractors

ICWP Services

- All CCSP services
- Behavioral Management
- Counseling
- Durable Medical Equipment
- Environmental Modifications
- Vehicle Adaptations

NOW/COMP Waiver

- New Options Waiver and Comprehensive Supports Waiver
- Serves developmentally disabled
- Refer resident to DBHDD/MFP (Tiffany Butler/Jennifer Wiseman) for referral to Regional Office of DBHDD for assessment
- See pg 16 of HCS booklet for services.

Which waiver is best for this transition?

	CCSP	SOURCE	ICWP	NOW/COMP
Member Profile:	Elderly or disabled (no age limit) who meets a nursing home level of care.	Elderly or disabled (no age limit) who meets a nursing home level of care. Must be receiving SSI or Public Law Medicaid.	More severely disabled, aged 21 to 64, such as wheelchair bound or acquired brain injury. Generally younger and have desire to live independently.	Developmentally disabled, such as intellectually disabled, autistic, cerebral palsy, etc.

How is admission determined?

	CCSP	SOURCE	ICWP	NOW/COMP
Initial screening by phone	Aging and disabled resource center (ADRC)	SOURCE case management agency	Georgia Medical Care Foundation (GMCF)	DBHDD Regional Office
Face to face Assessment	CCSP Care Coordination	SOURCE case management agency	GMCF	DBHDD Regional Office
LOC determination	CCSP Care Coordination	GMCF	GMCF	DBHDD Regional Office
LOC form and responsible person	Appendix E/5588 -CCSP Care Coordination	Appendix F – SOURCE case management agency	DMA-6 – member and case manager from personal physician	DBHDD Regional Office
Case management	CCSP Care Coordination	SOURCE case management agency	Private case manager/agency	DBHDD Regional Office

Who pays for the waiver services?

- Medicaid pays for these services, after cost share (if required).
- CCSP members must "cost share" in excess of SSI income limit.
- CCSP, ICWP and NOW/COMP classes of Medicaid eligibility are available for those not on SSI or another type of Medicaid.

What happens to Medicaid at discharge?

- A nursing home resident is on SSI or Nursing Home (NH) Medicaid while in the nursing home.
- At discharge to the community, those on NH Medicaid must have their eligibility "rolled over" to another class of Medicaid.
- This is called a Continuing Medicaid Determination (CMD) at the Dept of Family and Children Services.

What forms do I need to facilitate a CMD?

	CCSP	SOURCE	ICWP	NOW/COMP
NH Discharge Form	Get form <u>DMA-59</u> at discharge	Get form <u>DMA-59</u> at discharge	Get form <u>DMA-59</u> at discharge	Get form <u>DMA-59</u> at discharge
Level of Care (LOC) Form	Get copy of <u>Appendix E (Form 5598)</u> from CCSP care coordinator	Get copy of <u>Appendix E</u> from SOURCE case manager	Get copy of <u>DMA-6</u> from ICWP case manager	Get copy of <u>DMA-6</u> from Regional Support Coordinator
Communicator Form	Get copy of <u>Community Care Communicator (CCC)</u> from CCSP care coordinator	None required	Get copy of <u>ICWP Communicator</u> from ICWP case manager	Get copy of <u>NOW/COMP Communicator</u> from Regional Support Coordinator

What needs to be on the DMA-59?

- In Terminations section, marked "discharged" to "home with a health plan"
- "Health plan" is the waiver services.

What needs to be on the LOC form?

- Must indicate that the member meets a NH level of care.
- Must indicate that member can be helped with "community care" services.
- Must be signed by a physician.

What needs to be on the Communicator?

- The date the member began case management
- The date the member received their first services, also known as the "slot date"
- The month in which the "slot date" falls is the first month of Medicaid eligibility for CCSP or NOW/COMP.
- The beginning date of case management is the "slot date" for ICWP.

DISCHARGE PLANNING

- Request assessment for waiver services EARLY in the process.
- Ask NH to HOLD form DMA-59 until discharge date.

DAY OF DISCHARGE

- If SSI or potential SSI, take client to local Social Security office.
- If CCSP, ICWP or NOW/COMP, get DMA-59 from NH. Ask them NOT to send it to DFCS.
- Get communicator form and level of care form from case manager ASAPI

DAY OF DISCHARGE

- **Mark "MFP" at top of all forms to get priority and route to JW Wright and Sandy Taylor.**

DAY OF DISCHARGE

- Notify care coordinator (case manager) for waiver program that MFP participant is at home and ready to start services (e.g., personal support services, home delivered meals, etc.)

REMINDERS:

- Start waiver assessment process EARLY.
- Stay in touch with Care Coordinator (Case Manager) for Waiver Program.
- Get forms to Sandy Taylor for Medicaid eligibility on day of discharge or ASAP thereafter.

Routing Info for CMD Forms

- Send to Sandy Taylor at DCH MFP via the FTP site.

Contact info –

Tom Underwood

Phone: 404-463-8365

tunderwood@dch.ga.gov

MFP

AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY _____ CITY _____ MEDICAID PROVIDER NO _____ SOCIAL SECURITY NO _____

RECIPIENT'S NAME _____ RECIPIENT'S MEDICAID NO. _____ PRIMARY ICD-9-CM _____ SECONDARY ICD-9-CM _____ DATE OF BIRTH _____

SECTION II - ADMISSION

LEVEL OF CARE: 1-Skilled 2-IC 3-IC/AR

PATIENT ADMITTED FROM: A-Hospital B-Nursing Facility (NF) C-State Instn D-Own Home E-Other F-SNF Medicare

ADMISSION DATE: _____

VA AID & ATTENDANCE INCLUDED: Yes No

DMA-6 ATTACHED: Yes No

OMB ELIGIBLE: Yes No

PAYMENT EFFECTIVE DATES: _____

PATIENT INCOME: _____

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE: 1-Skilled 2-IC 3-IC/AR

LOC EFFECTIVE DATE: _____

VA AID & ATTENDANCE INCLUDED: Yes No

DMA-6 ATTACHED: Yes No

OMB ELIGIBLE: Yes No

PAYMENT EFFECTIVE DATES: _____

PATIENT INCOME: _____

SECTION IV - TERMINATIONS

REASON: F-ELIGIBLE F-DISCHARGED D-DED

EFFECTIVE DATE: _____

DISCHARGE DESTINATION: A-Home with a Health Plan B-Hospital C-Nursing Facility (NF) D-Other _____

E-Own Home F-SNF Medicare L-Limited Stay Exempt

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contribution by the 1st of each month.

Signature of Facility Administrator: X _____ DATE: _____

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker: X _____ County Code: _____ DATE: _____

DMA - 89 (Revised 6-83)

MFP

APPENDIX E

(CCSP)

Georgia Department of Human Services

COMMUNITY CARE SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section I - A. Identifying Information		2. Patient's Name (Last, First, Middle Initial)					
I. CCSP ASSESSMENT TEAM NAME ADDRESS		3. Home Address					
		4. Telephone Number;		5. County;		6. PSA	
7. Medicaid Number		8. Social Security Number			9. Mother's Maiden Name		
10. Sex	11. Age	12. Birthday	13. Race	14. Marital Status	15. Type of Recommendation 1. <input type="checkbox"/> Initial 2. <input type="checkbox"/> Reassessment		16. Referral Source

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Services with necessary information including medical data.

17. Signed _____ 18. Date _____

(Patient, Spouse, Parent or other Relative or Legal Representative)

B. Physician's Examination Report, Recommendation, and Nursing Care Needed			1. ICD	2. ICD	3. ICD
19. Diagnosis on Admission to Community Care (Hospital Transfer Record May Be Attached)			20. Is Patient free of communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		
1. Primary _____	2. Secondary _____	3. Other _____			

Medications (including OTC)				Diagnostic and Treatment Procedures			
21. Name	Dosage	Route	Frequency	22 Type Frequency			

23. COMMUNITY CARE SERVICES ORDERED

24. Diet	25. Hours Out of Bed Per Day		26. Overall Cond		27 Restorative Potential	28. Mental and Behavioral Status				
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other	<input type="checkbox"/> Intake <input type="checkbox"/> IV <input type="checkbox"/> Output <input type="checkbox"/> Bedfast <input type="checkbox"/> Catheter Care <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning		<input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Fluctuating <input type="checkbox"/> Deteriorating <input type="checkbox"/> Critical <input type="checkbox"/> Terminal		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Questionable <input type="checkbox"/> None	<input type="checkbox"/> Agitated <input type="checkbox"/> Noisy <input type="checkbox"/> Dependent <input type="checkbox"/> Confused <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Independent <input type="checkbox"/> Cooperative <input type="checkbox"/> Vacillating <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Violent <input type="checkbox"/> Well Adjusted <input type="checkbox"/> Forgetful <input type="checkbox"/> Wanders <input type="checkbox"/> Disoriented <input type="checkbox"/> Alert <input type="checkbox"/> Withdrawn <input type="checkbox"/> Inappropriate Reaction				
29. Debility	30. Bowel	31. Bladder	32. Indicate Frequency Per Week Physical Therapy		Occupational Therapy	Remotive Therapy	Reality Orientation	Speech Therapy	Bowel Bladder Retrain	Activities Program
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infected <input type="checkbox"/> On Admission <input type="checkbox"/> Surgery Date	<input type="checkbox"/> Continent <input type="checkbox"/> Occas. Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy	<input type="checkbox"/> Continent <input type="checkbox"/> Occas Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter								

33 Record Appropriate		IMPAIRMENT				ACTIVITIES				
Legend		Lid	Para-	1. Dependent		Wheel-	Trans-	Ambu-		
1. Severe				2. Needs Asst.		Chair	fers	Bath	lation	Dressing
2. Moderate		Sight	Hear	3 Independent		<input type="checkbox"/>				
3. Mild		<input type="checkbox"/>	<input type="checkbox"/>	4 Not App		<input type="checkbox"/>				
4. None										

34. This patient's condition <input checked="" type="checkbox"/> could <input type="checkbox"/> could not be managed by provision of <input checked="" type="checkbox"/> Community Care or <input type="checkbox"/> Home Health Services.		38. Physician's Name (Print)		
35. I certify that this patient <input checked="" type="checkbox"/> requires <input type="checkbox"/> does not require the intermediate level of care provided by a nursing facility.		39. Physician's Address (Print)		
36. I certify that the attached plan of care addresses the client's needs for Community Care.		40. Date Signed By Physician	41. Physician's Licensure No.	
42. Physician's Phone No.	37. Physician's Signature			
ASSESSMENT TEAM USE ONLY				

43. Nursing Facility Level of Care <input type="checkbox"/> Yes <input type="checkbox"/> No	44. L.O.S.	Certified Through Date
---	------------	------------------------

45. Signed by person certifying LOC:	Title	Date Signe
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MFP

(SOURCE)

APPENDIX F Admit Discharge Transfer Date/other Info

Georgia Department of Community Health
SOURCE LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section I - A. Identifying Information

1. SOURCE TEAM NAME & ADDRESS Telephone: Provider ID#		2. Patient's Name (Last, First, Middle Initial)				
		3. Home Address:				
6. Medicaid Number		7. Social Security Number		8. Mother's Maiden Name		
9. Sex	10. Age	11. Birthday	12. Race	13. Marital Status	14. Type of Recommendation 1. <input type="checkbox"/> Initial 2. <input type="checkbox"/> Reassessment	15. Referral Source

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Resources with necessary information including medical data.

16. Signed _____ (Patient, Spouse, Parent or other Relative or Legal Representative) 17
Date _____

Section B. Physician's Examination Report, Recommendation, and Nursing Care Needed

18. Diagnosis on Admission to Community Care (Hospital Transfer Record May Be Attached) 1. Primary _____ 2. Secondary _____ 3. Other _____			19. Is Patient free of communicable disease? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No			1. ICD	2. ICD	3. ICD
---	--	--	---	--	--	--------	--------	--------

20. Name				Dosage	Route	Frequency	21. Type Frequency		
----------	--	--	--	--------	-------	-----------	--------------------	--	--

22. SOURCE SERVICES ORDERED: ECMS, _____

23. Diet	24. Hours Out of Bed Per Day	25. Overall Condition	26. Restorative Potential	27. Mental and Behavioral Status		
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other	<input type="checkbox"/> Intake <input type="checkbox"/> IV <input type="checkbox"/> Output <input type="checkbox"/> Bedfast <input type="checkbox"/> Catheter Care <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning	<input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Fluctuating <input type="checkbox"/> Deteriorating <input type="checkbox"/> Critical <input type="checkbox"/> Terminal	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Questionable <input type="checkbox"/> None	<input type="checkbox"/> Agitated <input type="checkbox"/> Confused <input type="checkbox"/> Cooperative <input type="checkbox"/> Depressed <input type="checkbox"/> Forgetful <input type="checkbox"/> Alert	<input type="checkbox"/> Noisy <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Vacillating <input type="checkbox"/> Violent <input type="checkbox"/> Wanders <input type="checkbox"/> Withdrawn	<input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Anxious <input type="checkbox"/> Well Adjusted <input type="checkbox"/> Disoriented <input type="checkbox"/> Inappropriate Reaction

28. Decubiti	29. Bowel	30. Bladder	31. Indicate Frequency Per Week of the following services:						
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infected <input type="checkbox"/> On Admission Surgery Date	<input type="checkbox"/> Continent <input type="checkbox"/> Occas Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy	<input type="checkbox"/> Continent <input type="checkbox"/> Occas Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter	Physical Therapy	Occupational Therapy	Restorative Therapy	Reality Orientation	Speech Therapy	Bowel Bladder Retrain	Activities Program

32. Record Appropriate Legend				Record Appropriate Legend				Activities of Daily Living					
IMPAIRMENT 1. Severe 2. Moderate 3. Mild 4. None		Sight	Hear	Speech	Ltd Motion	Paralysis	1. Dependent 2. Needs Asst 34 Independent 4. Not App		Wheel-Chair	Transfers	Bath	Ambulation	Dressing
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. This patient's condition <input checked="" type="checkbox"/> could <input type="checkbox"/> could not be managed by provision of <input checked="" type="checkbox"/> SOURCE or <input type="checkbox"/> Home Health Services.			37. Physician's Name (Print)		
34. I certify that this patient <input checked="" type="checkbox"/> requires <input type="checkbox"/> does not require the intermediate level of care provided by a nursing facility			38. Address:		
35. I certify that the attached plan of care addresses the client's needs for Community Care			39. Date Signed By Physician		
36. Physician's Signature: <input checked="" type="checkbox"/>			40. Physician's Licensure No		
			41. Physician's Phone No		

ASSESSMENT TEAM USE ONLY

42. Nursing Facility Level of Care* <input type="checkbox"/> Yes <input type="checkbox"/> No	43. L.O.S. Certified Through Date	44. Signed by person certifying LOC	Title	Date Signed	Phone
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MFP

(NOW/COMP)

Type of Program: Nursing Facility CAPP EXTRA Audio-Beckett SMDP

PEDIATRIC DMA 6(A) PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A Identifying Information

1 Applicant's Name Address 2 Maiden and Number 3 Social Security Number 4 Sex Age 4A Birthdate 5 Primary Care Physician 6 Applicant's Telephone # 7 Date of Medical Application 8 Does child attend school? 9 Date of Medical Application

Section B Physician's Report and Recommendation 12 History (attach additional sheets if needed)

13 Diagnosis 14 Medication 15 Inappropriate and Treatment Procedures

16 Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documents)

17 Anticipated Dates of Hospitalization 18 Level of Care Recommended 19 Type of Recommendation 20 Patient Transferred from (check one) 21 Length of Time Care Needed 22 Is patient free of communicable disease? 23 This patient's condition could not be managed by provision of Home Health Services 24 Physician's Signature 25 I certify that this patient requires the level of care provided by a nursing facility, ICADR facility, or hospital 26 Date signed by Physician 27 Physician's License No 28 Physician's Telephone #

Section C Evaluation of Nursing Care Needed (check appropriate box only)

29 Nutrition 30 Mobility 31 Behavioral Status 32 Incontinence 33 Respiratory Status 34 Therapy/Needs 35 Neurological Status

36 Other Therapy Needs 37 Remark 38 Pre-Admission Certification Number 39 Date Signed 40 Print Name of MD or RN

DO NOT WRITE BELOW THIS LINE

41 Contacted Stay Review Date 42 Admission Date 43 Approval for Days or Months

44 Are nursing services, rehabilitative habilitative services or other health related services requested, regularly provided in an institution? 45 Hospitalization Pre-certification 46 Level of Care Recommended by Contractor

47 Approval Period 48 Signature of Contractor 49 Date 50 Attachment (if checked) 51 Yes No

DM 101 (10 2007)

MFP

Georgia Department of Human Services Resources
COMMUNITY CARE COMMUNICATOR (CCSP)

_____ CLIENT NAME			_____ COUNTY	_____ PSA NUMBER
_____ ADDRESS (STREET AND NUMBER)			_____ SOCIAL SECURITY NUMBER	_____ MEDICAID NUMBER
_____ CITY	_____ STATE	_____ ZIP CODE	_____ DATE OF BIRTH	_____ TELEPHONE NUMBER

SECTION I COMPLETED BY CARE COORDINATOR:

- I. The client has elected to accept Community Care Services Program: Case Management began effective 1/15/13 and the client was placed in service effective 2/4/13.
- The client is currently receiving MAO. Please calculate cost share.
 - The client has been referred for eligibility determination and cost share.
 - The client will require a home visit for application (Reason in Remarks).

Signature X Telephone No. X Date X

SECTION II COMPLETED BY DFCS MEDICAID WORKER:

- II. The date client applied for MAO _____
- The client has been determined Medicaid eligible effective _____
- The client is receiving Community Care Program Services and is responsible for contributing toward the cost.
- The client has a change in cost share.
- \$ _____ EFFECTIVE _____ \$ _____ EFFECTIVE _____ \$ _____ EFFECTIVE _____
- The client has been determined ineligible, effective _____ (Reason in Remarks).

Signature _____ Telephone No. _____ Date _____

SECTION III COMPLETED BY CARE COORDINATOR:

- III. The above named client is being released from the Community Care Services Program effective _____ for the following reason:
- Client deceased; Date of Death _____
 - Condition has improved; services no longer needed.
 - Condition has worsened; entering a nursing home. Name, if known _____
 - Other _____

Signature _____ Telephone No. _____ Date _____

SECTION IV COMPLETED BY CARE COORDINATOR or DFCS MEDICAID WORKER:

REMARKS: _____

MFP

(ICWP)

APPENDIX G
INDEPENDENT CARE WAIVER COMMUNICATOR

The purpose of this form is to establish the Independent Care 30 day length of stay requirement for individuals whose Medicaid eligibility is based on Independent Care Waiver participation. Case Managers are to complete Section I of this form and forward to the appropriate DFCS caseworker.

Member Name County Medicaid Number

Member Name County Medicaid Number

SECTION I - COMPLETED BY CASE MANAGER

I. The above member has elected to accept Independent Care Waiver Program services. Case Management began effective 1/17/13, and the member was placed in an ICWP slot effective 2/1/13.

- [] The member is currently receiving Medicaid. Please determine cost share.
- [] The member has been referred for Medicaid eligibility and cost share determination.

Signature X Date X

SECTION II - COMPLETED BY DFCS CASEWORKER

II. [] The member has been determined Medicaid eligible effective _____.
[] The member is receiving Independent Care Waiver services and is responsible for contributing \$ _____ monthly toward the cost effective _____.
[] The member has a change in cost share.

\$ _____ Effective _____
\$ _____ Effective _____
\$ _____ Effective _____

[] The above named member has been determined ineligible for Medicaid effective _____

Reason: _____

[] Other _____

Signature _____ Date _____

MFP

APPENDIX F
MR/DD WAIVER PROGRAM COMMUNICATOR
MAO DETERMINATION (NOW/COMP)

Participant Name _____ County _____ MHID # _____
Address _____ Soc. Sec. # _____ Medicaid # _____
City _____ State _____ Zip Code _____ Date of Birth _____ (Area Code) Phone # _____
Provider _____ Phone # _____

SECTION I COMPLETED BY PLANNING LIST ADMIN/SUPPORT COORDINATOR
1/25/13 Date participant was determined eligible for New Options Waiver (NOW)/Comprehensive Supports Waiver (COMP)

→ Signature: X _____ Date _____

SECTION II COMPLETED BY PLANNING LIST ADMIN/SUPPORT COORDINATOR (check those which apply)

- Participant currently resides in an ICF-MR which receives Medicaid reimbursement for his/her services. Please compute cost share. Discharge Date: _____
NOW/COMP Enrollment Date: _____
 Participant currently resides in the community and does not receive Medicaid. Please determine eligibility and cost share. Date services begin: 2/4/13
 Participant is currently receiving MAO. Please compute cost share.
 Participant needs annual re-determination of MAO status and cost share.
 Participant requires a home visit for application. (Reason in Remarks)

Signature: X _____ Phone No. X _____ Date X _____

SECTION III COMPLETED BY DFACS CASEWORKER

_____ Date participant applied for MAO ELIGIBILITY DATE: _____
\$ _____ Participant's cost share Effective Date: _____
\$ _____ Participant's cost share due to liability change Effective Date: _____
_____ Date participant was determined INELIGIBLE. (Reason in Remarks)

Signature: _____ Phone No. _____ Date _____

SECTION IV COMPLETED BY NOW/COMP PLANNING LIST ADMIN/SUPPORT COORDINATOR

This member has been released from the NOW/COMP effective _____, for the following reason.

Signature: _____ Phone No. _____ Date _____

SECTION V COMPLETED BY NOW/COMP SUPPORT COORDINATOR OR DFACS CASEWORKER

REMARKS:

Small Group Case Study Discussion
for HCBS Waiver Choices for MFP Transitions

In your small group, discuss a case history of one of the transitions with which you have assisted and why you and the nursing home resident/MFP participant chose the waiver program that assisted them on their return to the community. Discuss the following:

What factors influenced the choice of a particular waiver program?

Did you encounter any problems in getting the member/participant into the waiver?

Did you encounter any problems getting the member's Medicaid changed from NH Medicaid to the waiver Medicaid?

What would you do differently after participating in this training session?

Georgia Department of Community Health

MFP Policy Training



Presentation to: **Money Follows the Person Contractors**
 Presented by: **JEROME GREATHOUSE**
MFP Housing Manager

Date: 2/14/2013

Georgia Department of Community Health

Mission

The Georgia Department of Community Health
 We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

Georgia Department of Community Health

~Accessible~
 ~Affordable~
 ~Integrated~
Housing

Tip and tools for finding housing for MFP Clients

Qualified Residence Types Review

- ❖ A home owned by the individual or the individual's family member.
- ❖ An apartment with an individual lease, with lockable access and egress, which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.
- ❖ A residence in a community based setting, in which no more than (4) unrelated individuals reside.



3

Type of Housing Subsidy / Options Review

- ❖ Project Based Rental Assistance (PBRA) or Based on Income
- ❖ Low Income Tax Credit (LITC)
- ❖ USDA Rural Housing / 515
- ❖ Assisted Living Community
- ❖ Personal Care Home
- ❖ Housing Choice Voucher or Section 8 Voucher (The Golden Ticket)



4

Subsidy Housing Documentation Review

Required Documentation needed for subsidized housing:

- ❖ State issued ID (Valid/Current)
- ❖ Social Security Card
- ❖ Birth Certificate / Passport
- ❖ Proof of SS Income/ pension
- ❖ 6 months of bank statements



Each document listed will be required for all household members. In Addition, other information is sometime needed per property or application.



5

Housing Application & Inspection Tips



MFP Referral to Decatur Housing Authority Housing Choice Voucher Program

- Complete entire application
- Keep appointments made by HCV Program
- Request extensions if needed
- 120 days to locate housing in DeKalb County

Housing Inspections tips

- Ensure an inspection has been completed prior to move-in
- Ensure a Pre/Post inspection of the modification is conducted
- Ensure the modifications fit the participants needs

Affordable Housing Resources & Tools

Leave No Stone Unturned!

- ❖ www.georgiahousingsearch.com
- ❖ www.hud.gov/Research/Rental
- ❖ [www.dca.gov/LowIncomeTaxCredit\(LITC\)](http://www.dca.gov/LowIncomeTaxCredit(LITC))
- ❖ <http://rdmfh.rentals.sc.gov.usda.gov/RDMFH>
Rentals/Select_state.asp /USDA Subsidy housing
- ❖ www.gosection8.com
- ❖ www.fairrent.com
- ❖ <http://www.hud.gov/offices/hsp/aff/hcho/hos.cfm?webListAction=search&searchState=GA/>
HUD Approved Housing Counseling Agency
- ❖ options (rentals with roommates & personal care home)
- ❖ Network, Network, Network



Environmental Modifications

- MFP provides funds to make physical adaptations to a qualified residence, including a qualified residence under the Section 8 Housing Choice Voucher program or any 'qualified residence' 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.

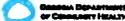
- Two scope/bid quotes are required for home modifications. Scope/bid quotes must come from licensed contractors and scope/bids must separate charges for labor and materials. Quotes from contractors must be based on using standard materials. Any materials used beyond basic/standard materials will be subsidized by the property owner.



Modifications v/s Renovations

Modification	Renovations
<ul style="list-style-type: none"> Basic Standard Materials Widen Doorway Grab Bars Rollin Shower Anti-skid material Adjustable shower head Cabinet knobs adjusted Eliminating step down threshold 	<ul style="list-style-type: none"> Using materials above to market price Adding double sinks Demolition of walls that are out of the scope of services Crystal Chandeliers / Granite countertops ???




9

Environmental Modifications







Basic Standard Materials


10

Questions / Issues

- Working Group Discussion
- Exercise
- Close


11

Georgia Department of Community Health

Post-Discharge Transition Planning Using the Post-ITP



Presentation to MFP Process Orientation Workshop
Presented by: Pam Johnson and RL Grubbs

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Georgia Department of Community Health

Mission

The Georgia Department of Community Health
We will provide Georgians with access to
affordable, quality health care through
effective planning, purchasing and oversight

We are dedicated to A Healthy Georgia.

Georgia Department of Community Health

Post-Discharge Transition Planning (Post-ITP)

- **Post-ITP - complete within 30 days of discharge**
- **Focus on Goals/Plans; Natural Supports; Network**
- **Housing Choice At Discharge**
 - Ask Q3 and code based on MFP housing type
 - indicate if there are problems that need to be resolved
- **Personal Goals/ Desired Community Outcomes**
 - Goals From Person Centered Planning
 - Short-term goals -- achievable in 6 mo to 1 year
 - Long-term goals -- 1 to 5 years

2

Post-Discharge Transition Planning (Post-ITP)

- The Plan for each area listed should include –
 - **Who** (does what)
 - **What** (the goal, the barriers to achieving/resources needed)
 - **When** (specific time frame to achieve)
 - **Where** (will the activity take place)
 - **Why** (is it important)
- Scenarios – Small Groups re-convene, complete Post-ITP and report



3

SCENARIO: Bob's Post-ITP

Bob is a 51-year-old person who is quadriplegic as a result of a diving accident, which occurred 1 ½ years earlier. He spent several months at an inpatient rehab facility that specializes in helping people who have spinal cord injury. After he finished rehab, he was transferred to a nursing facility 6 months ago. He is divorced, but has two adult children, a daughter and a son. His son lives in another state, but his daughter lives in the same town as Bob with her husband and children. Bob's parents are both deceased, and he has no siblings. Bob uses a power wheelchair for mobility. He needs assistance with many activities of daily living, such as bathing, dressing, and toileting/hygiene (e.g., catheter care/bowel program). He is unable to self-transfer or turn over independently in bed. He was approved for 7 hours/day of PSS by the ICWP waiver. He selected a case manager and discharged to an accessible apartment using a Section 8 HCV.

Bob's daughter wants him to move in with her because she thinks it is unsafe for her dad to live on his own. However, Bob wants to stay in his own apartment and go back to work. Prior to his injury, Bob worked for 20 years as a police officer. He is afraid no one will hire him now that he has a physical disability and isn't sure what jobs may be possible for him. He is also concerned about whether working would impact his Medicaid/benefits.

As a group, your task is to –

- Select a member to 'play' Bob
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on the group's discussion
- Use Person Centered Planning techniques to identify and develop short and long-term goals
- Complete the MFP Post-ITP

The Post-ITP should address all issues as listed. A Plan (who, what, when, where, and why) should be written up for achieving at least one goal in each area, with two identified barriers and two possible strategies for overcoming each barrier.

Once your group has completed the Post-ITP, the facilitator leads the group in a discussion of the following questions –

- How did we apply Person-Centered Planning?
- How did plans we developed contribute to the integration of the participant into the community? To the development of natural supports and networks?
- How did the plans we developed integrate MFP, waiver and other non-Medicaid/community services?

The note-taker/reporter will be asked to report the group's answers.

SCENARIO: Shelly's Post-ITP

Shelly is a 39 year old who has Bipolar Disorder. She was also recently diagnosed with diabetes (insulin-dependent). She was living with her mother in a mobile home. Due to financial struggles and inability to pay for heating during the winter months, Shelly developed frostbite in her feet for which she was hospitalized. During the hospitalization, she learned that she was diabetic and had both feet amputated. Shelly has been living in a nursing facility since her hospitalization, and although she has expressed a desire to return to the community, she does not want to move back in with her mom. Furthermore, Shelly feels unsafe moving back with her mom because she says the mobile home is "run down" and there are big holes in the floor. To further complicate things, Shelly allowed her mom to become her payee. Now that Shelly wants to move out on her own and become her own payee again, her mom is unwilling to relinquish that control over Shelly's finances. Shelly does NOT have a legal guardian. She is a bit of a loner and does not interact with other family and friends.

Shelly currently uses a manual chair for mobility, but would like to get some prosthetics to help her be able to walk again. She is experiencing difficulty adjusting to the amputation of her feet and is grieving this loss. She feels that no one understands her frustrations. Further, she is now feeling that the effects of her Bipolar Disorder are more difficult to manage. Shelly was approved for 4 hours per day of PSS by the ICWP waiver. She selected a case manager and discharged to a Personal Care Home with Adult Living Service.

As a group, your task is to –

- Select a member to 'play' Shelly
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on the group's discussion
- Use Person Centered Planning techniques to identify and develop short and long-term goals
- Complete the MFP Post-ITP

The Post-ITP should address all issues as listed. A Plan (who, what, when, where, and why) should be written up for achieving at least one goal in each area, with two identified barriers and two possible strategies for overcoming each barrier.

Once your group has completed the Post-ITP, the facilitator leads the group in a discussion of the following questions –

- How did we apply Person-Centered Planning?
- How did plans we developed contribute to the integration of the participant into the community? To the development of natural supports and networks?
- How did the plans we developed integrate MFP, waiver and other non-Medicaid/community services?

The note-taker/reporter will be asked to report the group's answers.

SCENARIO: Able's Post-ITP

Able is a man, 66 years of age. He was admitted to the nursing home a little over a year ago after an auto accident. He has rehabilitated to the point he is ready to discharge. Able is also diagnosed with Multiple Sclerosis. He is incontinent, uses a Hoyer lift to transfer, uses a power wheelchair, and has limited dexterity (he is able to write with a built-up pen). Able's wife has recently moved into a townhouse where the bedrooms are all upstairs. Able was approved for 4 hours per day of PSS under the CCSP waiver. He transitioned to project-based housing (project based rental assistance), a two bedroom apartment in a USDA apartment complex. The environmental modifications were completed within a day or two of his move.

As a group, your task is to –

- Select a member to 'play' Able
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on the group's discussion
- Use Person Centered Planning techniques to identify and develop short and long-term goals
- Complete the MFP Post-ITP

The Post-ITP should address all issues as listed. A Plan (who, what, when, where, and why) should be written up for achieving at least one goal in each area, with two identified barriers and two possible strategies for overcoming each barrier.

Once your group has completed the Post-ITP, the facilitator leads the group in a discussion of the following questions –

- How did we apply Person-Centered Planning?
- How did plans we developed contribute to the integration of the participant into the community? To the development of natural supports and networks?
- How did the plans we developed integrate MFP, waiver and other non-Medicaid/community services?

The note-taker/reporter will be asked to report the group's answers.

SCENARIO: Melissa's Post-ITP

Melissa is a 46 year old woman who has spent nearly half her life in institutions. Facility staff states she lashes out and has "behaviors." Her primary diagnosis is Cerebral Palsy. She can ambulate with a manual wheelchair but has difficulty making it up hills or other inclines. She is incontinent and cannot successfully change her disposable adult briefs without physical assistance. She states she wants to return to the community. Her income is limited to SSI. She has a community supporter who can help occasionally but will not be able to assist her every day. Melissa was approved for 4 hours per day of PSS under SOURCE waiver. She discharged to a Personal Care Home after environmental modifications were completed, including a ramp to the front door and roll-in shower and grab bars in her bathroom.

As a group, your task is to –

- Select a member to 'play' Melissa
- Select a facilitator – someone to lead the discussion
- Select a note-taker/reporter – someone to take notes and report on the group's discussion
- Use Person Centered Planning techniques to identify and develop short and long-term goals
- Complete the MFP Post-ITP

The Post-ITP should address all issues as listed. A Plan (who, what, when, where, and why) should be written up for achieving at least one goal in each area, with two identified barriers and two possible strategies for overcoming each barrier.

Once your group has completed the Post-ITP, the facilitator leads the group in a discussion of the following questions –

- How did we apply Person-Centered Planning?
- How did plans we developed contribute to the integration of the participant into the community? To the development of natural supports and networks?
- How did the plans we developed integrate MFP, waiver and other non-Medicaid/community services?

The note-taker/reporter will be asked to report the group's answers.

Peer Support, Life Skills Coaching, and MFP

Presenter
 Jayson Wright, MFP Specialist
 Georgia Division of Aging Services

Presentation to: Georgia Area Agencies on Aging MFP Staff

Date: February 4-5, 2013



Georgia Department of Human Services

Vision, Mission and Core Values

Vision
 Stronger Families for a Stronger Georgia.

Mission
 Strengthen Georgia by providing individuals and families access to services that promote self-sufficiency, independence, and protect Georgia's vulnerable children and adults.

Core Values

- Provide access to resources that offer support and empower Georgians and their families.
- Deliver services professionally and treat all clients with dignity and respect. Manage business operations effectively and efficiently by aligning resources across the agency.
- Promote accountability, transparency and quality in all services we deliver and programs we administer.
- Develop our employees at all levels of the agency.



Peer Support & Money Follows the Person

- Peer Support Providers
 - Centers for Independent Living
 - Independent Contractors
 - Shepherd Center Brain Injury Support Group
 - *Who do you use?*



Peer Support & Money Follows the Person

- Peer Support Providers
 - Must have a disability (but not same disability as peer)
 - Should have access to reliable transportation, as face to face visits are required
 - Should be able to document visits



Life Skills Coaching & Money Follows the Person

- Life Skills Coaching Process – After referral to LSC
 - 1) participant completes an individualized training needs assessment
 - 2) participant completes up to 30 hours of customized training focused on skill development
 - 3) can participate in individual and group activities designed to reinforce skill development
 - 4) trainer/coach must evaluate the impact of the training
- Trainer/Coach documents sessions, files final report



Life Skills Coaching & Money Follows the Person

- Life Skills Coaching Providers
 - Does not need to have disability (such as peer supporters)
 - Coaching can occur in one on one or congregate settings
 - Assessment should be done based on the skills the *person* wishes/needs to learn, not the opinion of the TC, CM, or Life Skills coach.



Life Skills Coaching & Money Follows the Person

- **Life Skills Coaching Providers**
 - Who has accessed LSC?
 - Who is providing LSC in your area?



TCARE and MFP

Presenters:
 Cliff Burt, Caregiver Specialist.
 Jayson Wright, MFP Specialist
 Georgia Division of Aging Services

Presentation to : MFP Process Orientation Workshop

Date February 5, 2013



 Georgia Department of Human Services

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- Develop our employees at all levels of the agency.



T-CARE™ & Money Follows the Person

- What prompted T-CARE™ & MFP?
 – Recent change to MFP Operational Protocol
 - Caregiver Training is now Caregiver Outreach & Education
- DCH & DAS both value T-CARE™ program benefits



T-CARE™ & Money Follows the Person

- Why T-CARE™ ?
 - It's already state-wide
 - It's evidence based
 - Data can be tracked (AIMS)
 - At rollout, T-CARE will be only supported model; Additional care models are being reviewed



T-CARE™ & Money Follows the Person

- Who's Involved?
 - MFP TCs
 - T-CARE™ Care Managers
 - All MFP Participants & Caregivers, regardless of waiver status
- Will Training be Needed?
 - TCs will received T-CARE™ basics on 1.25.2013
 - Care Managers will be trained on MFP basics and MFP billing



T-CARE™ & Money Follows the Person

- What's the Process?
 - MFP Participant and unpaid caregiver identified at ITP. Interest in TCARE is established at ITP.
 - MFP Participant and caregiver reach 90th day of MFP participation.
 - TC refers to TCARE Care Manager for screening and assessment process
 - TCARE Care Manager follows TCARE process and bills TC for services according to taxonomy



Georgia Department of Community Health

MFP Vendor Payments and Financial Forms



Presented To: MFP Process Orientation Workshop
Presented by: Sandy Taylor

Dec 26, 12

Georgia Department of Community Health

Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

MFP Vendor Import File to FI

- **MFP 3 Digit Service Codes – New Additions**
 - LSC – Life Skills Coaching
 - SMS – Specialized Medical Supplies
 - HIS – Home Inspection
- **COS Codes**
 - Deleted 851 – SOURCE Management
 - 930 for SOURCE
 - 990 – Unknown – Code used for participants who transition without a waiver

Georgia Department of Community Health

2

Vendor Import File - VIF

- Vendor Tax id – **no dashes**
- Member Name – **last name, first name**
- Member Medicaid Number – **no dashes**
- Member DOB and Transition Date/Service Date
– **format (mm/dd/yyyy)**
- Units and Rates – PES, PSS, LSC, SOR, COE and COB
- FI check # and Date Check issued by FI – **to be referred to DAS**



3

MFP Financial Forms

- Authorization for MFP Transition Services
– Deleted field – **Revised Authorization**
- Request for Additional MFP Transition Services
- Quote Form for MFP Transition Services
– Home inspection for all Environmental Modifications
– Building permit is required for modifications totaling \$2500 or more
- MFP Vendor Payment Request – New Addition
– MFP Ombudsman Payment Request Form



4

Contact Information

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Fax No.: 770-344-4060
staylor@dch.ga.gov



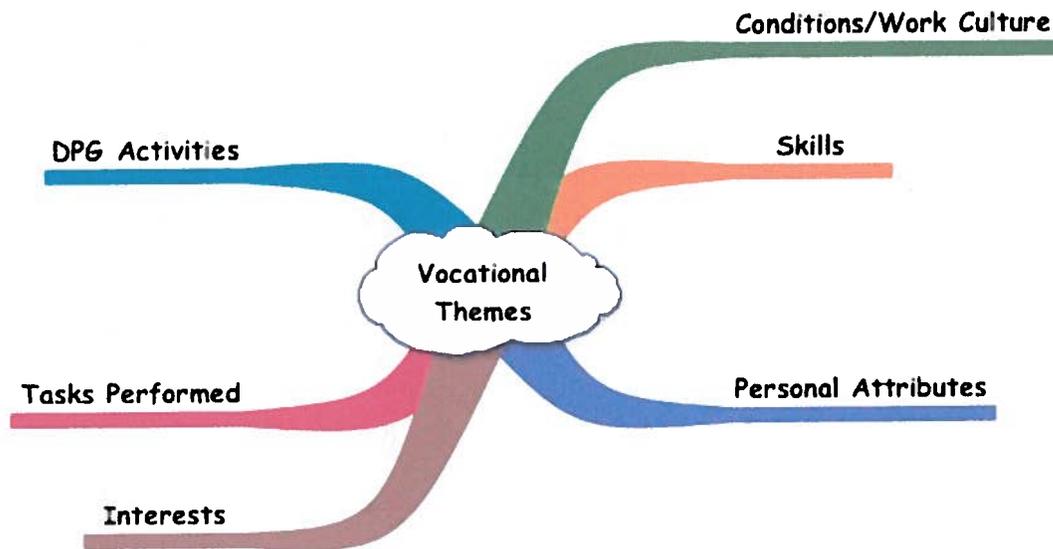
5

Developing Vocational Themes

Cary Griffin & Dave Hammis

Griffin-Hammis Associates & The Center for Social Capital

**Griffin-Hammis Associates:
Elemental Flow Chart for Developing Vocational Themes**



Developing Vocational Themes (Griffin-Hammis Associates)

This workbook is a **discussion guide** for those designing and overseeing **Discovering Personal Genius (DPG)** activities in order to capture critical elements for review by the “Discovery Team,” “Community Action Team,” the individual themselves, or any and all folks involved in establishing the vocational plan. *Training in DPG is highly recommended before using this tool.* This workbook supplements the **Discovery Staging Record (DSR)** and is meant to foster team conversation through the gathering of non-speculative observational data during DPG activities. Discussing the basic elements here, including the individual **DPG Activities**, the **Tasks** the individual performs, their **Interests**, the **Skills** they exhibit and those that can be built upon, their personal **Attributes** and **Characteristics**, and the **Conditions** of employment and the **Work Cultures** providing the best, most natural fit, helps discern the overarching **Vocational Themes**. These themes lead us to developing the **Lists of Twenty** places in our community “where the theme and career make sense.”

This workbook is designed for taking notes before and during DPG team meetings; the workbook is not meant to be another report...use it to inform your conversation and actions.

To briefly Recap: Discovering Personal Genius (DPG) is designed to generate no fewer than 3 overarching Vocational Themes. The themes are not job descriptions. They are large umbrella topics that represent an accumulation of many jobs, environments, skills/task sets, and interests. Too often someone may have an interest in say, flowers. The stereotypical job suggestion is likely to be: Work in a greenhouse or assist at a florist shop. This is very limiting for both the individual and the person charged with managing the career search. By thinking through the theme a bit, supported by DPG evidence of current skills, tasks that can potentially be taught/learned, and interests, as well as work environments & cultures that make sense, a broader, richer palette of opportunity emerges. By slowing down the process just a bit; engaging a team for ideas; and exploring the community using informational interviews and work try-outs, creative options emerge. And while none of us will ever be well versed in the intricacies of even a miniscule number of companies in our communities, the good news is that skills and tasks often transcend industry sectors. Someone who can wash a dish can also wash a car part in a solvent tank. DPG gets us to look in myriad places where similar skills and ecological fitment are found.

So, someone who helps their parents grow flowers in the family garden demonstrates that they know how to water the flowers, how to prune back dead leaves, and how to hoe weeds. This might mean, although additional Discovery is warranted, that there is an Agricultural Theme. This is not a flower or a plant theme; that would be too narrow. The same skills used in flower gardening are used across many types of agriculture (and within other themes too). The flower garden, after all, is likely the only place the opportunity to learn and perform these tasks has occurred. In fact, DPG challenges us to consider that this might not be an interest of the person at all. Perhaps this is just one of the only activities accessible to the individual. Still, the skills they have (watering, weeding, trimming) are relevant in many work environments and should not be dismissed. The DPG process helps determine where both interests and skills lie.

If Agriculture is indeed determined to be a theme through various DPG activities (e.g. a positive work try-out on a weeding team at the Botanical Gardens; trimming trees with in the backyard), then a List of Twenty is developed for that one theme....

Developing Vocational Themes (Griffin-Hammis Associates)

Activities: Briefly detail the DPG Activities observed to date. Discuss why they were chosen and what they revealed. What additional Activities are planned; What additional activities seem warranted?

Activity 1.

Activity 2.

Activity 3.

Activity 4.

Activity 5.

Add additional pages for more Activities...

Developing Vocational Themes (Griffin-Hammis Associates)

Tasks: In each of the Activities listed above, please describe the Tasks the individual performed during each (Note that a Task is generally a series of actions that complete a process: Changing the spark plug in a lawn mower is a task). Discuss the quality of the work performed; teaching & support strategies; where (and *where else*) these tasks are likely to be valued; new tasks that might be useful to introduce/teach...

Task 1.

Task 2.

Task 3.

Task 4.

Task 5.

Add additional pages for more Tasks...

Developing Vocational Themes (Griffin-Hammis Associates)

Skills: For the Tasks listed above, describe the discrete Skills exhibited during each (Note that a Skill is a learned/practiced action that contributes to the performance of a Task: Selecting the correct wrench; setting the gap of the spark plug are both discrete skills used when tuning up the lawn mower). Discuss the level of skill demonstrated; teaching & support strategies; where (and *where else*) these skills may be valued; new skills that might be useful to introduce/teach; and other skills the person has that are obvious or assumed even if not observed...

Skill 1.

Skill 2.

Skill 3.

Skill 4.

Skill 5.

Skill 6.

Skill 7.

Skill 8.

Skill 9.

Add additional pages for more Skills...

Developing Vocational Themes (Griffin-Hammis Associates)

Interests: The dictionary defines an interest as *an activity that diverts or amuses or stimulates*. The steps of DPG are designed to illuminate interests and the resident skills and tasks involved. Interests are important because being engaged augments skill development, but interests alone are not enough to build a job on; skills, even emerging ones, should also be in evidence. One discovers their interests through repeated exposure with family, friends, educational opportunities, and through personal exploration. Often, for individuals with significant disabilities, choices are limited and what appear as interests are actually the choices of others. List the Interests revealed through DPG observations & conversations. When discussing, match Interests with skills and tasks to help clarify *where the career makes sense*. Note that Interests often tend to be more like job descriptions than overarching themes. For instance, an Interest in Flyfishing may lead to the theme of Water, or Nature, or Animals, or perhaps Problem-Solving...

Interest 1.

Evidence of Interest:

Interest 2.

Evidence of Interest:

Interest 3.

Evidence of Interest:

Interest 4.

Evidence of Interest:

Add additional pages for more Interests...

Developing Vocational Themes (Griffin-Hammis Associates)

Personal Attributes: Describe the person in terms of personality or behavioral qualities they demonstrate. Be especially careful not to speculate; just report on what's been observed. Use these attributes as a guide to the type of environment most suitable/preferable for employment, and to determine what works and what doesn't work for the individual. Punctuality, style of dress, and sense of humor are common attributes. Note that attributes often inform the Conditions of Employment....

Attribute 1.

Attribute 2.

Attribute 3.

Attribute 4.

Attribute 5.

Attribute 6.

Attribute 7.

Attribute 8.

Attribute 9.

Add additional pages for more Attributes...

Developing Vocational Themes (Griffin-Hammis Associates)

Conditions of Employment/Work Cultures: These are the considerations for good worksite fitment and include such elements as preferred work hours, performance of specific tasks and the use of particular skills, regularity and intensity of supervision, etc. In almost any workplace, substantial deviation from the cultural norm of expected traits and performance may inhibit acceptance and inclusion, so knowing the Conditions and Cultural preferences of the individual minimizes bad job match. Note that the discussion again returns to asking: *where might folks with similar conditions work; where might such conditions be negotiated; where might this work culture exist in our community?*

Condition 1.

Condition 2.

Condition 3.

Condition 4.

Work Culture Element 1.

Work Culture Element 2.

Work Culture Element 3.

Work Culture Element 4.

Add additional pages for more Conditions/Cultural Elements...

Developing Vocational Themes (Griffin-Hammis Associates)

Vocational Themes: Based on the evidence collected and discussed so far, what are the solid themes; what are the emerging themes; what information do you need to solidify the list of Three Vocational Themes?

Solid Vocational Themes:

- 1.
- 2.
- 3.

Emerging Vocational Themes:

- 1.
- 2.
- 3.

What information and activities are needed to settle on the final list of Vocational Themes?

- 1.
- 2.
- 3.
- 4.

DISCOVERY STAGING RECORD

Instructions: This form is used to stage, structure, capture and record the major events of Discovery. The recorder(s) should pay particular attention to how the tasks are typically performed, any accommodations, technology, supports, or specialized training strategies that should be employed. Handwritten Discovery notes should be used in the field during the discovery activity with information summarized here.

Name:	Dates started/completed:
Family Contacts:	
Phone/E-mail:	Person(s) completing Discovery Record:
Additional Contact Information:	
Team Members:	
What are the responsibilities of each team member?	
Consultants/Experts to Contact:	
Comments/Considerations:	

Stage One: Home & Neighborhood Observation

Who will ensure this stage is completed? By what date?

Preliminary step: review records, files, assessments to establish current issues, cautions, training, etc., that may be of relevance:

Initial Interviews: Begin with the individual's home and/or family home (if residing there).

Date:

People interviewed & relationship to Individual:

Recap of Information (attach field notes, pictures):

Observations of home, bedroom, property, belongings that seem relevant:

Chores & tasks performed at home:

Hobbies, Sports, Collections, Interests noticed during home visit:

Family/friend/community activities individual engages in and regularity:

Neighborhood Mapping (resources, employers, transportation options, neighbors of interest, activities, civic engagement):

Talents, interests, skills, and tasks observable/revealed:

Activities, situations, & locations that need to be avoided:

Stage Two: Others to be interviewed

Name/relationship/role

1.
Person responsible: *by this date:*
2.
Person responsible: *by this date:*
3.
Person responsible: *by this date:*
4.
Person responsible: *by this date:*
5.
Person responsible: *by this date:*
6.
Person responsible: *by this date:*

Former school/rehab staff to be interviewed:

Person responsible: *by this date:*

Other family members and friends to be interviewed:

Person responsible: *by this date:*

What was learned from each:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Former school/rehab staff – information learned:

Other family members and friends – information learned:

Patterns Emerging: (Interests, Talents & Skills):

Request Benefits Planning Query (BPQY) from SSA: *They will be able to tell us what benefits the person has and how work will impact them.*

Date Requested:

Information Learned:

Workforce Incentive Liaison (WIL): *Schedule an appointment*

Date of Meeting:

Meeting Details:

Stage Two: Discovery Visits

Identify five places where this individual can be observed in activities that give context to their Interests, Talents & Skills – TAKE PHOTOS:

1.
Person responsible: by this date:
2.
Person responsible: by this date:
3.
Person responsible: by this date:
4.
Person responsible: by this date:
5.
Person responsible: by this date:

Note your observations for each location, date, the specific activities observed, and specific supports needed:

- 1.

- 2.
- 3.
- 4.
- 5.

Summary of supports needed during these activities (be specific):

What environments & activities need to be avoided and why?

What places, skills and activities need more exploration?

Where/when will this exploration occur?

Follow up needed including who is responsible and dates to be completed:

Stage Three: Vocational Themes (not job descriptions or business ideas)

Emerging themes that meld Interests, Talents, and Skills:

- 1.
- 2.
- 3.

Identify 3 places for each theme where people with similar themes work:

Theme 1:

- 1.
- 2.
- 3.

Theme 2:

- 1.
- 2.
- 3.

Theme 3:

- 1.
- 2.
- 3.

Select 2 places and arrange informational interviews.

1.

Person responsible: *by this date:*

2.

Person responsible: *by this date:*

Interview dates and notes:

1.

2.

Which themes seem strongest?

New interests/talents revealed?

Arrange further informational interviews and/or short (up to 1/2 a day) work experiences at the following places:

1.

<i>Person responsible:</i>	<i>by this date:</i>
2.	
<i>Person responsible:</i>	<i>by this date:</i>
What was observed:	
1.	
2.	

Stage Three: Vocational Profile
Summarize finding from Discovery and include the following in your description:

1. Interests, Talents, Skills as observed; best ecological fit; best learning mode/methodology; places/situations to avoid; personal resources (benefits, family support, savings, transportation); most endearing/engaging qualities; exploitable skills:
2. Ideal Conditions of Employment:
3. What “off the job” support will be needed and who will provide?
4. How will this person stay in contact with their friends, and who will ensure this?
5. How will this person get to and from work?
6. What is this person’s ideal work schedule (days and hours) and why?

Stage Four: Job/Business Development Plan
List of Twenty Places where people with similar Vocational Themes Work:

Theme 1:	Theme 2:	Theme 3:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
9.	9.	9.

10.	10.	10.
11.	11.	11.
12.	12.	12.
13.	13.	13.
14.	14.	14.
15.	15.	15.
16.	16.	16.
17.	17.	17.
18.	18.	18.
19.	19.	19.
20.	20.	20.

Create representational portfolios, picture books, resumes, and other tools for Job Development as needed:

Person responsible: *by this date:*

Stage Four: Informational Interview		
<u>Utilizing information gained during Discovery and summarized in the Vocational Profile, select 3 or 4 businesses from the list above and arrange Informational Interviews for job development</u>		
<i>Information learned:</i>	<i>Person responsible:</i>	<i>Date completed:</i>
Person responsible: by this date:		
Business Name:		
Contact person and title:		
Phone:	e-mail:	
Notes:		
Follow up (what, who and by when):		
JOB OFFER		
Description of job:		
Salary:	Days:	Hours:
Date offered:	<input type="checkbox"/> Accepted	<input type="checkbox"/> Declined Date:
Date of task analysis:	Start date:	
Person responsible: by this date:		
Business Name:		
Contact person and title:		
Phone:	e-mail:	
Notes:		
Follow up (what, who and by when):		
JOB OFFER		
Description of job:		
Salary:	Days:	Hours:
Date offered:	<input type="checkbox"/> Accepted	<input type="checkbox"/> Declined Date:
Date of task analysis:	Start date:	
Person responsible: by this date:		
Business Name:		
Contact person and title:		
Phone:	e-mail:	
Notes:		
Follow up (what, who and by when):		
JOB OFFER		
Description of job:		
Salary:	Days:	Hours:
Date offered:	<input type="checkbox"/> Accepted	<input type="checkbox"/> Declined Date:
Date of task analysis:	Start date:	

<i>Person responsible:</i>			<i>by this date:</i>		
Business Name:					
Contact person and title:					
Phone:		e-mail:			
Notes:					
Follow up (what, who and by when):					
JOB OFFER					
Description of job:					
Salary:		Days:		Hours:	
Date offered:		<input type="checkbox"/> Accepted		<input type="checkbox"/> Declined Date:	
Date of task analysis:				Start date:	
<i>Person responsible:</i>			<i>by this date:</i>		
Business Name:					
Contact person and title:					
Phone:		e-mail:			
Notes:					
Follow up (what, who and by when):					
JOB OFFER					
Description of job:					
Salary:		Days:		Hours:	
Date offered:		<input type="checkbox"/> Accepted		<input type="checkbox"/> Declined Date:	
Date of task analysis:				Start date:	
<i>Person responsible:</i>			<i>by this date:</i>		
Business Name:					
Contact person and title:					
Phone:		e-mail:			
Notes:					
Follow up (what, who and by when):					
JOB OFFER					
Description of job:					
Salary:		Days:		Hours:	
Date offered:		<input type="checkbox"/> Accepted		<input type="checkbox"/> Declined Date:	
Date of task analysis:				Start date:	

Vocational Profile Approvals

Participant Signature: _____ **Date:** _____

Conservator/Care Provider Signature: _____ **Date:** _____

Vocational Specialist Signature: _____ **Date:** _____

District Manager Signature: _____ **Date:** _____

Regional Vice President Signature: _____ **Date:** _____

February 4 – 5, 2013
MFP Process Orientation
Workshop
Current MFP Forms



Macon, Georgia

Georgia Department of Community Health
Medicaid Division/Aging and Special Populations
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Appendix B: MFP Services and Rate Table Revised 011513

Medicaid Rate	Pre-Transition Service	Procedure Code	Modifiers	MFP 3 Digit Service Code	Rate	Description (for full description, see MFP Policy & Procedures Manual Chapter 603)	Maximum Cost per Service
Enhanced	Peer Community Support	T2038	Q2, U1	PES	1 unit = one hour contact, billable in quarter-hour increments, at \$50 per unit/hour; a maximum of 40 units/hours, for a total not to exceed \$2,000, ends on day 365 of the demonstration period. Rate includes all costs associated with delivery of service.	This service provides for face-to-face visits before, during and after transition, from a qualified and where available, a certified peer supporter for the purpose of discussing transition experiences, problem solving and building connections to individuals and associations in the community. A case note is required to document each contact. ***	\$2,000
Enhanced	Trial Visit- Personal Support Services (PCH/CRA)	T2038	Q2, U2	PSS	1 unit of personal support = the current rate provided by the appropriate wavier. 1 unit of residential services = 1 day at \$65 per day. In NOW/COMP, 1 unit of CLSS/CRA = 1 day at \$156, not to exceed \$1044 per member, ends on day 365 of the MFP demonstration period.	This service provides a brief period of personal support services or residential services 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; interact with staff in the personal care home or community residential alternative and/or assist the owner/vendor to identify, develop and improve the PSS staff skills necessary to accommodate the needs of the participant. On a case-by-case basis, this service can be used post-transition by a participant who's PSS services are arranged but delayed. ***	\$1,044
Enhanced	Household Furnishing	T2038	Q2, U3	HHF	Limited to \$1,500 per participant - ends on day 365 of the MFP demonstration period.	This service provides assistance to participants requiring basic household furnishings to help them transition back into the community. This service provides initial set-up assistance with a qualified residence. ***	\$1,500
Enhanced	Household Goods and Supplies	T2038	Q2, U4	HGS	Limited to a maximum of \$750 per participant, to be used during the 365 day demonstration period. \$200 of the \$750 can be used for a one-time purchase of groceries.	This service provides assistance to participants requiring basic household goods (see Appendix P). This service is intended to help the participant with the initial set-up of their qualified residence. ***	\$750
Enhanced	Moving Expenses	T2038	Q2, U5	MVE	Limited to a maximum of \$850 per participant - to be used during the 365 day demonstration period.	This service may include rental of a moving van/truck and staff or the use of a moving or delivery service to move a participant's goods to a qualified residence. Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used throughout the 365 day demonstration period. ***	\$850
Enhanced	Utility Deposits	T2038	Q2, U6	UTD	Limited to \$500 per participant- ends on day 365 of the MFP demonstration period.	This service is used to assist participants with required utility deposits for a qualified residence. On a case-by-case basis, this service can be used to pay past-due utility bills in order to re-connect utilities to a qualified residence. ***	\$500
Enhanced	Security Deposits	T2038	Q2, U7	SCD	Limited to \$1,000 per participant- ends on day 365 of the MFP demonstration period.	This service is used to assist participants with housing application fees and required security deposits for a qualified residence. ***	\$1,000
Enhanced	Transition Support	T2038	Q2, U8	TSS	Limited to \$600 per participant – ends on day 365 of the demonstration period.	This service provides assistance to help participants with unique transition expenses (obtaining documentation, accessing paid roommate match services, etc.). This service provides funding for needs that are unique to each participant, but necessary for a successful transition. ***	\$600
Enhanced	Transportation	T2038	Q2, U9	TRN	1 unit = a one-way trip, up to \$500. Service is designed to cover the cost of multiple one-way or round trips totaling no more than \$500, can be used pre and post-transition, ends on day 365 of the demonstration period.	This service assists participants with transportation needed to gain access to community services and resources (i.e. housing). This service is used when other forms of transportation are not otherwise available. This service does not replace the Medicaid non-emergency transportation (for medical appointments) or emergency ambulance services. ***	\$500
Enhanced	Life Skills Coaching	T2038	Q2, U10	LSC	1 unit = one half- hour of contact training/coaching or group/individual training activities, billable at \$25 per half-hour, to a maximum of 60 units or 30 hours training/coaching, limited to \$1,500 per participant, ends on day 365 of the demonstration period. Rate includes all costs associated with the delivery of service.	This service provides for life skills coaching and independent living skills training. Participants must be assisted to: 1) complete an individualized training needs assessment (ITNA), 2) complete up to 30 hours of customized training focused on skill development, lead by a qualified trainer/coach 3) participate in individual and group activities designed to reinforce skill development, and 4) evaluate the impact of the training. This service requires structured, instructor-lead, customized training/coaching based on the results of the ITNA. The trainer/coach documents training/coaching with a case note and reports the results of the evaluation. ***	\$1,500
						Not to exceed	\$10,244

Appendix B: MFP Services and Rate Table Revised 011513

Medicaid Rate	Post-Transition Service	Procedure Code	Modifiers	MFP 3 Digit Service Code	Rate	Description (for full description, see MFP Policy & Procedures Manual Chapter 603)	Maximum Cost per Service
Enhanced	Skilled Out-of-Home Respite	T2038	Q2, U11	SOR	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. On a case-by-case basis this service can be used by a participant who is waiting for environmental modifications to be completed to their qualified residence. ***	\$1,880
Enhanced	Caregiver Outreach & Education	S5110	Q2, U12	COE	1 unit = one half- hour of contact caregiver training, billable at \$25 per half-hour, to a maximum of 40 units or 20 hours, delivered by a qualified caregiver specialist, limited to \$1,000 per participant, ends on day 365 of the demonstration period. Rate includes all costs associated with delivery of service.	This service provides outreach, information, referral and education to caregivers who support MFP participants. This service includes; 1) an assessment that identifies sources of a caregiver's stress, 2) consultation and education with a qualified, trained caregiver specialist to develop a Caregiver Support Plan with strategies to reduce caregiver stress and 3) assistance to identify and obtain local services and resources to meet the caregiver's needs. The qualified caregiver specialist documents activities with case notes. This service is not provided in order to educate paid caregivers. ***	\$1,000
Enhanced	Home Care Ombudsman	T2038	Q2, U13	HCO	1 unit = one hour contact at \$150 per hour, billable in quarter-hour increments at \$37.50, limited to \$1,800 per participant, ends on day 365 of the demonstration period. Rate includes all costs associated with delivery of service.	This service provides regular monthly contacts made by a qualified home care ombudsman, for review of a transitioned participant's health, welfare and safety; provides advocacy for participants to respond to and resolve complaints related to MFP and waiver services and how these services are provided. Service is limited to participants who transition into a qualified residence (see Appendix A for details). Three face-to-face contacts are required, the first F2F contact must be completed within 30 days of discharge; additional monthly contracts (F2F or phone contacts) can be arranged as needed. A case note is required to document each contact. ***	\$1,800
Enhanced	Equipment, Vision, Dental and Hearing Services	T2038	Q2, U14	EQS	Limited to \$4,000 per participant - ends on day 365 of the MFP demonstration period.	This service provides equipment, vision, dental, hearing aids and related services and certain types of assistive technology and services that are not otherwise covered by Medicaid. Items and services obtained must be justified in the Pre/Post-ITP/ISP and be necessary to enable participants to interact more independently and/or reduce dependence on physical supports and enhance quality of life. Covers normal and customary charges associated with one vision examination and one pair of basic prescription glasses. Covers normal and customary charges for one dental examination and cleaning and/or dental work necessary to maintain or improve independence, health, welfare and safety. Covers normal and customary charges for hearing aids and related services. Two quotes are required for purchase of a single piece of equipment costing \$1000 or more. ***	\$4,000
Enhanced	Specialized Medical Supplies	T2038	Q2, U15	SMS	Limited to \$1,000 per participant - ends on day 365 of the MFP demonstration period.	Service includes various specialized medical supplies that enable MFP participants to maintain or improve independence, health, welfare and safety and reduce dependence on the physical support needed from others. The service includes incontinence items, food supplements, special clothing, bed wetting protective chucks, diabetic supplies and other supplies that are identified in the approved in the Pre/Post-ITP/ISP and that are not otherwise covered by Medicaid. Ancillary supplies necessary for the proper functioning of approved supplies are also included in this service. Two quotes are required for the single purchase of specialized medical supplies costing \$1000 or more. ***	\$1,000
Enhanced	Vehicle Adaptations	T2038	Q2, U16	VAD	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 driving controls, mobility device carry racks, lifts, vehicle ramps, wheelchair tie-downs and occupant restraint systems, special seats and other interior modifications for access into and out of the vehicle as well as to improve safety while moving. Two quotes are required for adaptations costing \$1000 or more. ***	\$6,240
Enhanced	Environmental Modification	T2038	Q2, U17	EMD	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 a qualified residence, including qualified residences under the Housing Choice Voucher or Other Housing Subsidy program or a community home on a case-by-case basis. This service covers basic modifications needed by a participant to ensure health, welfare and safety and/or to improve independence in ADLs. Two scope/bids are required, three scope/bids are recommended. Total scope/bids of \$2,500 or more, require building permits. The MFP Home Inspection Service must be completed prior to beginning the environmental modifications and after modifications are completed to ensure participant health, welfare and safety and quality work. ***	\$8,000
Enhanced	Home Inspection	T2039	Q2, U18	HIS	1 unit = one inspection with relevant report from a qualified inspector, billable at \$250, limited to \$1,000, ends on day 365 of the MFP demonstration period.	This service provides for home/building inspections, required before and after MFP Environmental Modifications (MFP-EMD) are undertaken. This service is used to identify and report on needed structural repairs to a qualified residence and to identify and make recommendations for appropriate and cost-effective environmental modifications before they are started. This service also provides for post-inspections after modifications are complete, in order to ensure quality work and compliance with relevant building codes and standards. The inspector providing the service is not affiliated with the contractors providing the environmental modifications. ***	\$1,000
Enhanced	Supported Employment Evaluation	S5110	Q2, U19	SEE	1 unit = one complete Vocational Discovery Process with Vocational Profile and referrals to a minimum of three community resources, limited to \$1,500 per participant, ends on day 365 of the demonstration period.	This service provides assistance to participants seeking career planning and supportive, customized and/or competitive employment. Participants engage in a guided/facilitated Vocational Discovery Process. Based on the Discovery Process, a Vocational Profile is completed. The Vocational Profile identifies a path to employment. These services may be procured from a qualified vocational/employment service provider. The provider is required to assist the participant to make connections to a minimum of three unique community resources necessary to support choices for supportive, customized and/or competitive employment. ***	\$1,500
Maximum Post-transition cost							\$26,420

***MFP service procedures are based on authorized and approved services as specified in the participant's transition service plan.** Q2-HCFA/ORD demonstration project procedures / service; U- Medicaid Level of Care (1 thru 20), as Defined by Georgia Medicaid (DCH)



Authorization for MFP Transition Services



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

MFP Field Personnel note: complete the following to authorize MFP Transition services that were included in the participant's Individualized Transition Plan. Each MFP service included must have been selected, justified and initialized by the participant in the ITP.

Participant First Name: _____ **Participant Last Name:** _____
Participant Medicaid ID#: _____ **Participant Date of Birth:** _____
Participant Address: _____ **Participant City:** _____ **Zip:** _____ **County:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
(Anticipated) Transition Date: _____ **COS Waiver Type:** _____

Vendor	Pre Transition Services	\$'s Authorized

Total Pre-Transition \$'s Authorized:

(Pre-transition services are not to exceed \$10,244.00 in the 365 day demonstration period).

Vendor	Post Transition Service	\$'s Authorized

Total Post-Transition \$'s Authorized:

Post-Transition services are not to exceed \$26,420 in the 365 day demonstration period.

MFP Field Personnel Name: _____

Office Location: _____ Phone: _____ Email: _____

Authorizing Signature: _____ Date Signed: _____

Notice: (Step 1) Send this completed *Authorization* to Fiscal Intermediary via **File Transfer Protocol (FTP)**. (Step 2) Send this complete *Authorization* to the DCH/MFP Office via FTP.



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 ID #: _____

Health Plan Name: _____

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

- MFP Field Personnel *
- Waiver assessment/case management staff *
- My Representative (Legal, etc.) *
- MFP service providers (Peers, Ombudsman, etc.) *

** Personnel located in Georgia and in the state to which you are transitioning.*

Purpose of requested use or disclosure: ⁱⁱ for screening and assessment and participation in MFP. 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 inpatient facility 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 transactions related to my participation in Money Follows the Person on matters related to services provided to me through Money Follows the Person.

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.



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.**



CHECKLIST FOR TRANSITION TO THE COMMUNITY



(For Use with Participants Transitioning to CCSP/SOURCE or ICWP)
Rev_011513

Participant Name: _____ Medicaid ID #: _____ DOB: _____

Current Location: _____ Best Contract Phone #: _____

Current Address: _____ City: _____ Zip: _____

Step	Responsible	Action Step/Notes	Results
1. Referral is received and participant is identified as eligible for screening. Setup appointment for face to face (F2F) screening with inpatient/family.	<ul style="list-style-type: none"> Referral Source MFP Field Personnel 		
2. Begin F2F screening using <i>MFP Transition Screening Form</i> . Determine eligibility for MFP. Ensure participant has expressed a desire to leave the institution. Participant is eligible based on following criteria. <ul style="list-style-type: none"> Inpatient for at least 90 consecutive days At least one day of stay was paid by Medicaid Meets institutional level of care Will resettle into qualified housing 	<ul style="list-style-type: none"> Participant MFP Field Personnel 		
3. 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> 	<ul style="list-style-type: none"> MFP Field Personnel Participant 		
4. Complete screening and conduct review of facility records to verify information obtained during screening. Verification of guardianship obtained if applicable.	<ul style="list-style-type: none"> Participant MFP Field Personnel 		
5. Provide participant with copies of and review the <i>Home and Community Services: A Guide to Medicaid Waiver Programs in Georgia</i> , and the <i>MFP Brochure</i> .	<ul style="list-style-type: none"> Participant MFP Field Personnel 		



CHECKLIST FOR TRANSITION TO THE COMMUNITY



(For Use with Participants Transitioning to CCSP/SOURCE or ICWP)
Rev_011513

Participant Name: _____ Medicaid ID #: _____ DOB: _____

Step	Responsible	Action Step/Notes	Results
6. MFP Transition Screening Form and attachments are complete to determine appropriate waiver referral and then sent to assigned waiver program for pre-screen. If referred to a waiver, the participant accepts waiver referral recommendation.	<ul style="list-style-type: none"> • MFP Field Personnel • MFP Participant 		
7. Assist participant to recruit a transition team (to include the participant's circle-of-support, other identified stakeholders and inpatient facility discharge planners).	<ul style="list-style-type: none"> • Participant • MFP Field Personnel 		
8. Convene the transition team and complete pre-discharge transition planning and the <i>Pre-ITP</i> . Establish short and long-term goals. At a minimum, the team identifies and describes in the Pre-ITP the need for qualified residence type/living arrangements, health and nutrition goals, 24/7 emergency backup plans, a personal care physician or clinic and a pharmacy in the community.	<ul style="list-style-type: none"> • Participant • Circle of Support • MFP Field Personnel 		
9. The transition team assists the participant/family in identifying and selecting appropriate MFP transition services (Pre-ITP Part A) and generic waiver services and other community service (Pre-ITP Part B). Assist the participant to begin a housing search using tools available including www.georgiahousingsearch.org	<ul style="list-style-type: none"> • Participant • Transition Team/Circle of Support • MFP Field Personnel 		
10. Identify and list Pre-ITP Plan Assignments for the participant, family/friends and support/transition team. All persons participating in the development of the Pre-ITP sign the Pre-ITP Signature Page. Field personnel distribute copies to participant and all members of the transition team.	<ul style="list-style-type: none"> • Participant • Transition Team • MFP Field Personnel • Waiver CC/CM 		



CHECKLIST FOR TRANSITION TO THE COMMUNITY



(For Use with Participants Transitioning to CCSP/SOURCE or ICWP)
Rev_011513

Participant Name: _____ Medicaid ID #: _____ DOB: _____

Step	Responsible	Action Step/Notes	Results
11. Process <i>MFP Authorization for Transition Services</i> . Arrange for vendors to provide pre-transition services.	<ul style="list-style-type: none"> • MFP Field Personnel • Vendor • DCH/MFP 		
12. Initiate pre-transition services.	<ul style="list-style-type: none"> • MFP Field Personnel 		
13. Arrange pre-transition visit of participant to community setting. Review potential qualified residences and identify community transportation options.	<ul style="list-style-type: none"> • Participant • MFP Field Personnel • Peer supporter • Waiver CC/CM 		
14. <i>Quality of Life</i> (QOL) survey completed 30 days prior to discharge but not later than 10 days post-discharge.	<ul style="list-style-type: none"> • Participant • MFP Field Personnel 		
15. Date established for participant discharge from institution. Review of Pre-ITP with transition team. Have all tasks been completed as identified in the Pre-ITP?	<ul style="list-style-type: none"> • Participant • MFP Field Personnel • Waiver CC/M 		
16. Day of discharge: <ul style="list-style-type: none"> • Supply change of address for social security benefits • Provide copy of discharge paperwork to DCH/MFP • Vendors submit <i>Request for Vendor Payment</i> to MFP field personnel with supporting documentation, after delivery to the participant in the community. <p>Field personnel must submit <i>Vendor Import File</i> to the Fiscal Intermediary (FI) and DCH/MFP office with supporting documentation.</p> <p>*Note: Will appear as needed throughout the billing process</p>	<ul style="list-style-type: none"> • Participant • MFP Field Personnel • DCH/MFP 		



CHECKLIST FOR TRANSITION TO THE COMMUNITY



(For Use with Participants Transitioning to CCSP/SOURCE or ICWP)
Rev_011513

Participant Name: _____ Medicaid ID #: _____ DOB: _____

Step	Responsible	Action Step/Notes	Results
17. <i>Discharge Day Checklist</i> is completed and submitted to DCH MFP.	<ul style="list-style-type: none"> MFP Field Personnel 		
18. Completed discharge documents / information forwarded to DCH MFP via FPT – <ul style="list-style-type: none"> DMA - 59 with the last date of institutional care indicated, DMA - 6 OR Level of Care document, <i>Communicator</i> indicating date for waiver admission (used only for non-SSI participants) 	<ul style="list-style-type: none"> MFP Field Personnel DCH/ MFP 		
19. DCH MFP enrolls participant into MFP assignment plan. Waiver services begin.	<ul style="list-style-type: none"> DCH /MFP Waiver CM/CC Waiver service providers 		
20. MFP field personnel conduct scheduled follow-up visit within 30 days of discharge to conduct post-discharge transition planning and complete the <i>Post-ITP</i> . Arrange for and initiate post-discharge MFP transition services.	<ul style="list-style-type: none"> Participant MFP Field Personnel Waiver CC/CM 		
21. Coordinate and/or arrange for the 2 nd Quality of Life (QoL) survey to be completed at 11 months post-discharge.	<ul style="list-style-type: none"> MFP Field Personnel QoL Surveyor Participant 		



Money Follows the Person Participant Complaint Form



Use this form to report a complaint regarding a MFP service delivered to a participant. Complete separate form for each complaint and for each service.

Participant First Name:

Participant Last Name:

Participant Medicaid ID#:

Date of Birth (mm/dd/yyyy):

Address:

City:

Zip:

County:

Participant Phone Number:

Other Contact Name:

Other Contact Phone Number:

Discharge Date (mm/dd/yyyy):

Waiver Name:

MFP Field Personnel Name:

Phone:

Date of Complaint (mm/dd/yyyy):

Name of Person Completing Form:

Summary of Complaint/Issues to Resolve:

Action Plan:

Process Improvement (what was instituted to evaluate the action plan and reduce risk to the participant?)

Define follow-up time frames (Act/Monitor) for evaluating effectiveness of process:

If applicable, complete information and select the MFP service that is focus of complaint:

Vendor	MFP Transition Service

Note: Send this completed *Participant Complaint Form* to the DCH MFP Office via File Transfer Protocol or by fax to the MFP Project Director, Pam Johnson at 770-408-5883.



Money Follows the Person



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Notice of Denial or Termination Letter

To: _____

Date: _____

Your participation in Money Follows the Person (MFP) has been given careful consideration.

A. In accordance with Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304, and the Georgia Money Follows the Person Policy and Procedures Manual Chapter 601.2, 601.4, 601.7 and 602.2, you have been determined **ineligible** for MFP because:

- You have not resided in an inpatient facility (hospital, nursing facility, ICF) for at least 90 consecutive days; short-term rehabilitative stays do not count.
- 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 did not transition into a qualified residence.
- You did not cooperate in the transition planning process (describe process/steps and non-participation):

B. In accordance with Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304, and the Georgia Money Follows the Person Policy and Procedures Manual Chapter 601.2, 601.4, 601.7, 602.2, 604.6, and Chapter 605.6 and 605.7, you have been determined **no longer eligible** because:

- You are no longer receiving Medicaid benefits.
- You have moved to a non-qualified residence.
- You no longer meet institutional level of care criteria.
- You have informed us that you no longer wish to participate in MFP.
- You have moved outside of the service area for the State of Georgia.
- You have been readmitted to an inpatient facility for a period of six (6) months or more.

MFP Field Personnel Signature

MFP Field Personnel (Print Name)

Telephone Number

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



Money Follows the Person



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Notice of Denial or Termination Letter

To: _____

Date: _____

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



MFP Discharge Day Checklist



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

MFP Field Personnel Name/Phone #:	Date:
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MFP Participant Housing at Discharge

Participant Name:	Medicaid ID#	Date of Birth:
New Address:	City:	Zip:
		County:
Phone Number	MFP Target Population (check only one): <input type="checkbox"/> OA (65+yoa) <input type="checkbox"/> PD <input type="checkbox"/> TBI <input type="checkbox"/> DD	Change Of Address Notification To: <input type="checkbox"/> DFCS <input type="checkbox"/> Social Security <input type="checkbox"/> Other (specify) _____

Housing Type: 01-Home owned by Participant 02-Home owned by Family Member 03-Apt/House Leased by Participant, Not Assisted Living
 04-Apt. Leased by Participant, Assisted Living 05-Group Home of No More Than 4 People/PCH **Lives with family (check for yes)**

Housing Subsidy: If H3-Apt/House Leased by Participant, check box for housing subsidy used: HS1- Sec8 HCV, HS2-Project Based Rental Assistance/ Based On Income, HS3- Low Income Housing Tax Credit , HS4- Other Subsidy (specify) _____ HS5-No Subsidy/Market Rate

Services at Discharge: Item Key: N=Needed; O=Ordered; S = Secured; N/A=Not Applicable

Items (provide items for all that apply):

___ Environmental Modifications; ___ Security Deposit; ___ Utility Deposits: _____; ___ Other: _____

___ Household items: ___ Kitchen: _____; ___ Bath: _____; ___ Bed: _____

___ Food & Nutrition: _____

___ Health & Hygiene: _____

___ RX Medications _____

___ Medical Services/DME Equipment: _____

___ Assistive Technology Devices: _____

___ Life Skills/ Socialization: _____

___ Financial: _____

___ Transportation: _____

___ Other:(list) _____

Waiver:	Waiver Case Manager/Care Coordinator/Planning List Admn/Case Expeditor:	Phone:
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Waiver services ordered at discharge:
 _____; _____; _____;
 _____; _____; _____;

Are providers identified to begin services upon discharge?: Yes No* If no, explain:

Name of Community Pharmacy:	Name of Community Doctor/Clinic:
-----------------------------	----------------------------------

24/7 Emergency plan reviewed: Yes No If no, explain:

Identify participant's unmet needs upon discharge and the plan to meet these unmet needs: (attach additional sheets as needed)

Follow-up Visits/Quality Management

Home Visits: Provide schedule for follow up visits:

Field Personnel/TC: 1st Scheduled Visit to complete Post-ITP: _____; 2nd Scheduled Visit: _____

Waiver Case Mgr /Care Coordinator/Support Coordinator/PLA Name: _____ Phone: _____
 1st Scheduled visit: _____; 2nd Scheduled Visit: _____

Home Care Ombudsman Name: _____ Phone: _____ Email: _____
 1st Scheduled F2F visit (or n/a): _____; 2nd Scheduled Visit: _____

County DFCS Office Contact: _____ Phone: _____ Email: _____

Quality of Life Survey: Baseline Survey - Completed Scheduled: _____ Rescheduled: _____

Participant Tracking

<input type="checkbox"/> This report sent to DCH MFP Office attention: _____ <input type="checkbox"/> This report faxed to participant's Case Manager/Care Coordinator	Date:
---	-------



Money Follows the Person Enrollment End Letter



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

DATE

PARTICIPANT NAME

PARTICIPANT ADDRESS

PARTICIPANT CITY, STATE ZIP

Dear **PARTICIPANT NAME**,

On **DATE**, you discharged from an inpatient facility into the community through Money Follows the Person (MFP). Participation in MFP is limited to 365 calendar days. Your 365 days of enrollment in MFP will end on **DATE**.

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 inpatient 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 Money Follows the Person. If you have any questions about this letter, you may contact MFP field personnel at the number below, or you may call the MFP State Office at the Georgia Department of Community Health Medicaid Division at 404-651-9961.

Sincerely,

MFP Field Personnel Print Name

Contract Phone #

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						

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)



Money Follows the Person Informed Consent for Participation

I, _____, (print name) voluntarily agree to be screened and assessed as part of my application for participation in the Money Follows the Person (MFP) projectⁱ. MFP Field Personnel 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 daysⁱⁱ.

By signing this Informed 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 MFP Brochure and a copy of the *Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia* booklet. I understand the MFP project guidelines including enrollment requirements. I understand that MFP one-time transitional services are provided under the MFP 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 an inpatient facility, 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.

Signature

Date

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

Date

MFP Field Personnel Sign

ⁱ Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304

ⁱⁱ If the MFP participant needs to be readmitted to an inpatient facility for a period of 30 days or less, the participant remains enrolled in the MFP demonstration. As soon as the participant's condition stabilizes, the participant can return to the community and resume services. When an MFP participant is readmitted into an inpatient facility for a period of time greater than 30 days (31 days or longer), the participant is discharged from the MFP demonstration and is considered an institutional resident. However, the discharged MFP participant will be re-enrolled, prior to the completion of 365 days, back into the demonstration without re-establishing the 90-day institutional residency requirement. The individual is considered an MFP participant when discharged from the inpatient facility, and is eligible to receive MFP services for any remaining days up to 365. MFP field personnel determine if any changes to the participant's Individualized Transition Plan are needed to prevent a re-admission to an inpatient facility. If the participant is readmitted to an inpatient facility for a period of longer than six months, the participant will be re-evaluated like a "new" MFP participant.

***Please fill in the necessary data for [MONTH YEAR]**

Cumulative numbers from the beginning of your MFP program until the date indicated below	Baselines	One Year Follow-Ups	Two Year Follow-Ups
<u>Completed</u> from start of program until [END OF PREVIOUS MONTH]	All baselines completed in your state since beginning an MFP program	All One Year Follow-Up surveys (11 months after transitioning) completed in your state since beginning an MFP program	All Two Year Follow-Up surveys (24 months after transitioning) completed in your state since beginning an MFP program
<u>Refused</u> from start of program until [END OF PREVIOUS MONTH]	All beneficiaries who transitioned into the community, but refused to take the survey after the transition	All MFP-enrolled beneficiaries who completed the baseline survey, but refused to take the follow-up survey 11 months after transitioning	All MFP-enrolled beneficiaries who completed the baseline survey, but refused to take the follow-up survey 24 months after transitioning
<u>Missed</u> from start of program until [END OF PREVIOUS MONTH]	All beneficiaries who transitioned into the community, but were not administered the survey due to factors such as (but not limited to): <ul style="list-style-type: none"> • Interviewers were unable to locate the beneficiary • Interviewers were unable to reach the beneficiary within 15 attempts • Beneficiary's paperwork was misplaced • An interviewer forgot 	All MFP-enrolled beneficiaries who completed the baseline survey, but were not administered the follow-up survey due to factors such as (but not limited to): <ul style="list-style-type: none"> • Interviewers were unable to locate the beneficiary • Interviewers were unable to reach the beneficiary within 15 attempts • Beneficiary's paperwork was misplaced • An interviewer forgot 	All MFP-enrolled beneficiaries who completed the baseline survey, but were not administered the follow-up survey due to factors such as (but not limited to): <ul style="list-style-type: none"> • Interviewers were unable to locate the beneficiary • Interviewers were unable to reach the beneficiary within 15 attempts • Beneficiary's paperwork was misplaced • An interviewer forgot
<u>Lost</u> (died, out of state, etc.) from start of program until [END OF PREVIOUS MONTH]	All beneficiaries who transitioned into the community, but died or moved out of state before a baseline was administered within the appropriate time frame.	All MFP-enrolled beneficiaries who completed the baseline survey, but died or moved out of state before the 11-month follow-up survey was administered within the appropriate time frame.	All MFP-enrolled beneficiaries who completed the baseline survey, but died or moved out of state before the 24-month follow-up survey was administered within the appropriate time frame.
<u>Completed</u> from start of program until [END OF THIS MONTH, LAST YEAR]	All baselines completed in your state from the beginning of the program to the end of this month last year.		
<u>Completed</u> from start of program until [END OF THIS MONTH, TWO YEARS AGO]	All baselines completed in your state from the beginning of the program to the end of this month two years ago.		

Just to clarify, the last two rows of the table asks for the **cumulative number of completed baselines from the beginning of your MFP program until THE END OF THIS MONTH, LAST YEAR and the **cumulative number** of completed baselines from the beginning of your MFP program until THE END OF THIS MONTH, TWO YEARS AGO. This information is necessary for us to track the percentage of completed first year follow-ups and second year follow-ups.

Helpful Hints:

- Submission of this monthly document is a requirement for all states participating in MFP.
- Follow-up surveys (both 11- and 24-month) should be administered after the initial transition into the community. Even if a participant was disenrolled or moved back into a managed care organization between the time of the transition and the one-year anniversary of the initial transition, the follow-up interview should still be conducted about 11 or 12 months after the initial transition. (When the 2-year follow-ups are done, the vast majority of people should not be eligible for MFP, so the MFP eligibility status doesn't affect the timing of follow-up interviews.)
 - For example, for an initial transition on 11/3/2010, the first year follow-up should be done about 11 or 12 months later and the second year follow-up about 24 months later, regardless of where the person is living or the person's MFP eligibility status (the person has to be alive). This means the first year follow-up for this individual should be due around 11/3/2011 and the second year follow-up should be around 11/3/2012.
- Baseline surveys should be administered no earlier than 1 month before transition and no later than 2 weeks after transition.
- Follow-up surveys should be completed no more than 60 days post-11 and -24 month follow-up dates. Keep in mind the follow-up dates are based on the beneficiary's transition date and not the baseline date.
- You should attempt to complete all follow-up surveys for MFP participants, regardless if they missed or refused any surveys at any point in time. If a participant missed the baseline survey, hopefully we will get their 1st and 2nd follow-ups and can use those for comparison.
- For non-MFP participants (i.e. those who don't transition out of managed care organizations or who move back into managed care organizations after living in the community), follow-up surveys should not be conducted. Follow up surveys are only conducted for MFP participants.

CMS pays for every baseline survey conducted, even if the person doesn't transition or participate in the program. You can find the full explanation in this document:

http://training.mathematica-mpr.com/file.php/11/General_Information/Helpful_guidelines_for_MFP_formatted_normal.pdf
- CMS may pay for repeated baseline interviews. We prefer the interview to be administered as close to the time of transition as possible, but know that's not always possible. Typically, if QoL administrators think something significant has changed since the previous baseline that may (or may not) change answers to the QoL questions, then it should be repeated.



Ombudsman Payment Request



MFP Ombudsman Services Rendered for:

Participant Name:	Participant/Contact Phone:
Participant Address:	Participant City /Zip /County

MFP Ombudsman Complete:	
Participant Medicaid ID#:	Participant Date of Birth:
Discharge Date:	Anticipated MFP End Date:

PAYMENT INSTRUCTION

Ombudsman Name:	Ombudsman Phone:
MAIL CHECK TO (if different):	Tax ID, FEIN or SS#:
Address:	City/State/Zip

DESCRIPTION OF MFP OMBUDSMAN SERVICES

Service Dates and Description	Billed Amount
Total Check Amount	

Ombudsman note: Check the appropriate box below to indicate how services were provided and documented -

- telephone call – contact must be documented in case notes, no participant signature required on this form
- in-person (face-to-face) – contact must be documented in case notes, participant signature required on this form

By signing this form, I attest that services were delivered/received consistent with the Individualized Transition Plans (ITPs) or Person Centered Description and MFP Authorization for Services. I understand that Medicaid is the payer of last resort.

MFP Participant Signature **Date**

Ombudsman Signature **Date**

MFP Field Personnel (Print Name): _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Ombudsman note: send this completed form to MFP field personnel via fax or file transfer protocol (FTP).

MFP Field Personnel note: once verified, send this completed form to the Fiscal Intermediary by **FTP**. Send this completed form to DCH MFP office by **FTP**.



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

Pre-Transition Individualized Transition Plan (Pre-ITP)

1. MFP PARTICIPANT INFORMATION

Participant First Name: _____ MI: __ Last Name: _____

Date of Birth (mm/dd/yyyy) _____ SSN: _____ - _____ - _____

Medicaid ID # _____ Medicare # _____

Inpatient Facility Name and Address: _____

City, Zip and County: _____

This is an (check only one): Initial Pre-ITP –OR-- Updated Pre-ITP Date: _____

2. IMPORTANT PLANNING DATES

Projected Discharge/Move-out Date: _____ Actual Discharge/Move-out Date: _____

3. HOUSING CHOICE/LIVING ARRANGEMENTS

Check if participant will live with family. Name _____

Address _____

City _____ ST _____ ZIP _____

Check if participant has someone that she/he wants to live with.

Name _____

Contact Phone _____ Other Phone _____

Check the housing choice expressed by the participant/family. Is housing choice needed?

Check Housing Choice	Participant / Family Has? Y/N	Participant / Family Needs? Y/N
<input type="checkbox"/> 01- Home owned by participant		
<input type="checkbox"/> 02- Home owned by family member		
<input type="checkbox"/> 03- Apt/house leased by participant, not assisted living		
<input type="checkbox"/> 04- Apartment leased by participant, assisted living		
<input type="checkbox"/> 05- Group home of no more than 4 people/ PCH		

Note: If participant has living arrangements in place, go to Q4 Health and Nutrition. If “Participant/Family Needs” is marked “Y”, describe problem/issue, strategies for resolving and tasks that must to be done to secure choice:

(Continue narrative on back or add additional pages as needed)

Note to field personnel: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

4. HEALTH AND NUTRITION GOALS:

List Health Related Needs	Who can help? What resources are available to help?	Health Improvement Goal

Ex: Rx med supply, specialized medical supplies, skin care/wounds, bowel/bladder program, etc.

List Nutrition Related Needs	Who can help? What resources are available to help?	Nutrition Improvement Goal

Ex: diet and restrictions, food preferences, preparation strategies, food supplies, etc.

5. 24/7 EMERGENCY BACKUP PLANS:

List Risks to Health/Safety	Describe Plan to Address Risk	Emergency Backup Plan

Ex: natural disasters, power outages, PSS doesn't show up, equipment failures, falls/injuries, etc.

6. OTHER ISSUES (Unique to Participant and Necessary for Discharge)

Goal/Issue	Barriers/Needs	Plan/Resource

(Continue narrative on back or add additional pages as needed)

Note to field personnel: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

PRE-TRANSITION PLAN ASSIGNMENTS:

Assignment	Person Responsible	Projected Date of Completion	Actual Date of Completion

Recommended Assignments: Who will assist with the following -

- Conduct Housing Searches; Arrange Environmental Modifications/Home Inspections
- Arrange Community Transportation Services/Travel Training
- Resolve Legal Issues
- Arrange Peer Support/Independent Living Skills Training/Life Skills Coaching
- Arrange Counseling/Behavioral Health Needs
- Schedule Home Care Ombudsman Visits; Arrange Caregiver Outreach and Training
- Locate Community Pharmacy for Refills of Rx Medications
- Locate Primary Care Physician/Clinic; Schedule Medical/Dental/Specialist Appointments
- Complete Waiver Enrollment; Select Case Mgt/Care Coordinator, Service Providers
- Complete Quality of Life Survey
- Referrals for Durable Medical Equipment and Assistive Technology

PRE-ITP TEAM SIGNATURE PAGE (signatures of persons who assisted in development of the Pre-ITP)

Print Name/Title or Relationship	Signature

Field Personal Contact

Name: _____ Date: _____

Phone: _____ Email: _____

(Continue narrative on back or add additional pages as needed)

Note to field personnel: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

Post Discharge-Individualized Transition Plan- Post-ITP

(Must be completed within first 30 days post discharge)

1. MFP PARTICIPANT INFORMATION

Participant First Name: _____ MI: __ Last Name: _____

Date of Birth (mm/dd/yyyy) _____ SSN: _____ - _____ - _____

Medicaid ID # _____ Medicare # _____

Address: _____

City, Zip and County: _____

Discharge Date (mm/dd/yyyy): _____ Moving Date: _____

2. Waiver Name _____

Waiver Case Manager/Care Coordinator Name _____

CM/CC Phone _____ Email _____

3. HOUSING CHOICE AT DISCHARGE

Check Housing Type at Discharge	Problems/Comments
<input type="checkbox"/> 01. Home owned by participant	
<input type="checkbox"/> 02. Home owned by family member	
<input type="checkbox"/> 03. Apartment leased by participant, not assisted living	
<input type="checkbox"/> 04. Apartment leased by participant, assisted living	
<input type="checkbox"/> 05. Group home of no more than 4 people/ PCH	

Notes:

4. PERSONAL GOALS/ DESIRED COMMUNITY OUTCOMES

Personal Goals/ Desired Community Outcomes	Barriers to Achieving Goals/Needs	Plan/Resources for Barrier Removal

Notes:

(Continue narrative on back or add additional pages as needed)

Note to field personnel: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

5. SENSORY/COMMUNICATION GOALS

Includes – vision, hearing, dental, mobility, speech/language and general communication goals.

Sensory/Communication Goals	Barriers to Achieving Goals/Needs	Plan/Resources for Barrier Removal

6. SOCIAL/RECREATIONAL GOALS

Activity Goals	Barriers/Needs	Plan

7. HOUSEHOLD/PERSONAL CARE GOALS (from Screening - Q34/DON-R)

Goals	Barriers/Needs	Plan

(Continue narrative on back or add additional pages as needed)

Note to field personnel: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

8. ASSISTIVE TECHNOLOGY (AT) AND/OR DURABLE MEDICAL EQUIPMENT (DME) USE AND NEEDS (from Screening, use Q32 and Q33)

Assistive Tech/DME Needs	Who can help/Resources?	Plan (who does what)

9. COMMUNITY ACCESS/TRANSPORTATION GOALS

Goals	Barriers/Needs	Plan

10. EMPLOYMENT GOALS – supported, customized, competitive and/or self-employment or volunteer/work without pay (complete if applicable)

Goals	Barriers/Needs	Plan

(Continue narrative on back or add additional pages as needed)

Note to field personnel: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

11. OTHER ISSUES (Unique to Participant and Necessary for Successful Transition)

Goals/Issues	Barriers/Needs	Plan/Resources

12. INCOME and RESOURCES – Create a budget for community living

Budget Categories	Monthly Amounts/Costs	Notes
Monthly Income (all sources)		
Housing (rent, utilities) costs		
Food costs		
Debts		
Medical, health care, prescription drugs costs		
Personal items, movies, entertainment costs, etc.		
Transportation costs		
Other		
Other		
Other		

(Continue narrative on back or add additional pages as needed)

Note to field personnel: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

POST-DISCHARGE TRANSITION PLAN ASSIGNMENTS:

Assignment	Person Responsible	Projected Date of Completion	Actual Date of Completion

Recommended Assignments: Who will assist with the following -

- Conduct Housing Searches; Arrange Environmental Modifications/Home Inspections
- Arrange Community Transportation Services/Travel Training
- Resolve Legal Issues
- Arrange Peer Support/Independent Living Skills Training/Life Skills Coaching
- Arrange Counseling/Behavioral Health Needs
- Schedule Home Care Ombudsman Visits; Arrange Caregiver Outreach and Training
- Locate Community Pharmacy for Refills of Rx Medications
- Locate Primary Care Physician/Clinic; Schedule Medical/Dental/Specialist Appointments
- Complete Waiver Enrollment; Select Case Mgt/Care Coordinator, Service Providers
- Complete Quality of Life Survey
- Referrals for Durable Medical Equipment and Assistive Technology

POST- ITP TRANSITION TEAM SIGNATURE PAGE (signatures of persons who assisted in development of the Post-ITP)

Print Name/Title or Relationship	Signature

MFP Field Personal Contact

Name: _____ Date: _____

Phone: _____ Email: _____

(Continue narrative on back or add additional pages as needed)

Note to field personnel: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed ITPs to DCH MFP via **FTP**.



Quote Form For MFP Transition Services

Notice to MFP field personnel: complete this *Quote Form* for equipment, supplies, vision and/or dental services costing \$1000 or more, all environmental modifications and/or all vehicle adaptations for MFP participants. In the table provided, list the licensed contractors or vendors and the amount of each quote. Check the quote selected. If a quote is selected that is not the lowest quote, provide a justification for the selected quote. MFP field personnel sign the form and attach supporting documentation. For assistance in locating qualified and licensed contractors Certified in Aging-in-Place (CAPS), contact DCH MFP Housing Manager.

Participant First Name: _____ **Participant Last Name:** _____
Participant Medicaid ID #: _____ **Participant Date of Birth:** _____
Inpatient Facility Name or NA: _____
Participant Address: _____ **Participant City:** _____ **Zip:** _____ **County:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
Date(s) of ITPs/Planning Meetings: _____ **COS Waiver Name:** _____

Vendor Name/Phone	MFP Transition Service	MFP 3 Digit Service Code	Quoted Amount	Check Accepted Quote
				<input type="checkbox"/>
				<input type="checkbox"/>

Total \$'s Authorized: _____

Justification for selection of quote that is not the lowest:

- Maximum allowed cost for Equipment, Vision, Dental and/or Hearing Services (EQS) is \$4,000 in the 365 day demonstration period. Two quotes must be obtained before a purchase can be authorized for a single piece of equipment costing \$1000 or more, or for vision, dental or hearing services costing \$1000 or more.
- Maximum allowed cost for Specialized Medical Supplies is \$1,000 in the 365 day demonstration period. Two quotes must be obtained before a purchase can be authorized for a single supply costing \$1000.
- Maximum allowed cost for Vehicle Adaptations (VAD) is \$6,240 in the 365 day demonstration period. Two quotes must be obtained before Vehicle Adaptations can be authorized.¹
- Maximum allowed cost for Environmental Modifications (EMD) is \$8,000 in the 365 day demonstration period. Two itemized scope/bids are required, before Environmental Modifications are authorized. Building permits are required for EMDs totaling \$2,500 or more. The Home Inspection service (HIS) must be completed before beginning environmental modifications and after environmental modifications are completed to ensure quality work and compliance with relevant building codes and standards. Environmental modifications can be made to rental property for participants who have a Housing Choice Voucher or other housing subsidy.¹

Owner/Landlord Name: _____ **Phone:** _____
Address: _____ **City:** _____ **Zip:** _____ **County:** _____
MFP Field Personnel Name: _____
Region/Office: _____ **Phone:** _____ **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 MFP participant.
MFP field personnel note: (Step 1) Send this completed *Quote Form* to Fiscal Intermediary via **File Transfer Protocol (FTP)**. (Step 2) Send this completed *Quote Form* to the DCH MFP Office via FTP.



MFP Referral Letter for



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Decatur Housing Authority Sec 8/HCV Program

Georgia Department of Community Health • Medicaid Division • Money Follows the Person
Two Peachtree Street, NW • 37th Floor • Atlanta, GA 30303 • 404-651-9961

Date of Referral Letter Submission: _____

This letter serves as official correspondence for the MFP direct referral process for the Decatur Housing Authority (DHA), *Housing Choice Voucher Program*.

The MFP participant (print name), _____, is being referred for application to the DHA *Housing Choice Voucher Program* by MFP field personnel (print name), _____.

The Decatur Housing Authority has entered into an agreement to assist MFP participants with a rental assistance voucher upon approval of the DHA *Application for Housing Choice Voucher Rental Assistance*. The Department of Community Health 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 and Decatur Housing Authority, 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 MFP field personnel and is hereby requesting an application for participation in the *DHA Housing Choice Voucher Program* in Dekalb county. The participant's screening is complete. The participant's Pre-ITP is in the process of being completed with an anticipated discharge date of: _____.

MFP Participant Information (Print)

First Name: _____ MI: _____ Last Name: _____

Medicaid ID#: _____ SSN: _____ -- ____ -- ____

in Household (include PCA if applicable) _____

Signature of MFP Participant Requesting Application _____

By signing, I understand and agree to the terms and expectations set forth in this official MFP referral for the *DHA Housing Choice Voucher Program*. Based on this official correspondence, I am hereby requesting a *DHA Application for Housing Choice Rental Assistance* for the number of household members listed above.

MFP Field Personnel Information

Note: the *Application for Housing Choice Rental Assistance* will be mailed to designated MFP field personnel. When field personnel receive the Housing Choice Voucher Application packet, **she/he and the MFP participant have 14 business days to complete and mail the application back to Decatur Housing Authority**, to the person at DHA the application was mailed from.

MFP Field Personnel Contact (print address for all correspondence)

Name: _____ Phone: _____

Mailing Address: _____

City/State/Zip Code: _____

Note: Complete and send this MFP referral letter to the DCH/MFP office by File Transfer Protocol, attention:

MFP Housing Manger, DCH
2 Peachtree Street NW, 37th Floor, Atlanta, Georgia 30303



Money Follows the Person Referral Form



Date (mm/dd/yyyy): _____

Person making referral: _____

Agency making referral: _____ Phone Number: _____

Person Referred-Name: _____ Phone Number: _____

Date of Birth (mm/dd/yyyy): _____ Age: _____

Inpatient Facility:

Address: _____

City: _____ ST: _____ ZIP: _____ County: _____

Contact Person: _____ Phone Number: _____

Admission Date to Inpatient Facility (mm/dd/yyyy): _____

Anticipated Referral: CCSP SOURCE ICWP Date Referred: _____
NOW COMP Other _____ Date Referred _____

Currently on wait list for: CCSP SOURCE ICWP
NOW COMP Other _____

Letter or contact info from the waiver: Yes No

Case Manager if assigned _____ Phone Number: _____

Interested Parties:

Name: _____ Relationship: _____

Street: _____ Phone Number: _____

City: _____ ST _____ ZIP: _____

Name: _____ Relationship: _____

Street: _____ Phone Number: _____

City: _____ ST _____ ZIP: _____

Pertinent Information: _____

Money Follows the Person (MFP)
Department of Community Health
Medicaid Division, Aging & Special Populations
2 Peachtree St. NW, 37th Floor
Atlanta, GA 30303

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

Project Director Phone: 404-651-9961



Request for Additional MFP Transition Services



MFP Field Personnel note: 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 during pre-discharge transition planning (i.e. the Pre-ITP/ISP) by the team. The MFP participant initials each additional service.

Participant First Name: _____ **Participant Last Name:** _____
Participant Medicaid ID#: _____ **Participant Date of Birth:** _____
Participant Address: _____
Participant City: _____ **Zip:** _____ **County:** _____ **Waiver Name:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
Date of Post-ITP: _____ **Date of Discharge:** _____ **Date of Request:** _____

MFP TRANSITION SERVICE	RATIONALE (provide justification for why this additional MFP service is needed to support successful living in the community)	MFP PARTICIPANT INITIAL

MFP Field Personnel Name: _____
Region/Office: _____ **Phone:** _____ **Email:** _____

Field Personnel note: Send this completed form to the DCH/MFP Office via **File Transfer Protocol (FTP)**. Contact the DCH/MFP Office regarding the dispensation of this request. If approved by DCH/MFP, submit completed reimbursement documentation (i.e. updated ITP, *Vendor Import File*, etc.) to Fiscal Intermediary via **FTP** and to DCH/MFP Office by **FTP**.

<p>For DCH/MFP Office Use Only</p> <p>Additional MFP Services Authorized: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>



Money Follows the Person

Notice of Right to Appeal a Decision

To: _____

Date: _____

If you disagree with a decision regarding your MFP transition services, you have a right to appeal the 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.

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. With your written request, you must include a copy of this Notice of Right to Appeal a Decision. Your written 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 MFP transition 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 Field Personnel Signature

MFP Field Personnel (Print Name)

Telephone Number



MFP Sentinel Event Reporting Form



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

MFP Field Personnel: complete this form when an MFP participant experiences a critical incident or 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: **Waiver CM/CC/SC Name:** **CM/CC/SC Phone:**
Participant First Name: **Participant Last Name:**
Participant Medicaid ID#: **Participant Date of Birth:**
Name & Address of the Inpatient Facility Admitted to: (or n/a):
Participant Address: **Participant City:** **Zip:** **County:**
Participant Phone Number: **Other Contact Name:** **Other Phone:**
Provider (if applicable):

Date of Incident:

Location of Occurrence:

Type of Sentinel Event: (Check only one)

- Abuse, Neglect, Exploitation, Inpatient Facility Admit,
- Emergency Room Visit, Death, Involvement with Criminal Justice System,
- Medication Administration,
- Other (specify):

Detailed summary of event:

What did the participant report?

Adverse outcomes related to the event/injuries? Describe in detail:

Witnesses to the event:

Action taken by MFP field personnel at time of event (Discovery):



MFP Sentinel Event Reporting Form



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

MFP Field Personnel Action Plan (Do): (What will field personnel do to prevent this from happening in the future?)

MFP Field Personnel Process improvement (Check): (What MFP processes were instituted to evaluate the effectiveness of the action plan and reduce risk to the participant?)

Define follow-up time frames (Act/Monitor) for evaluating effectiveness of processes.

Notification:

	Name	Date	Time
Field Personnel 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		
MFP Project Director:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Agency Name:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Agency Name:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MFP Field Personnel Name: _____ Phone: _____ Email: _____

MFP Field Personnel Signature: _____ Date: _____

Note: Send this completed *MFP Sentinel Event Form* to the DCH MFP Office by FTP.



Money Follows the Person Transition Screening Form



Participant Name: _____

1. Do you want to live somewhere other than this facility? Yes No

Screening Type/Date (Check one box) <input type="checkbox"/> Initial F2F Screening _____ (mm/dd/yyyy) <input type="checkbox"/> F2F Re-screening _____ (mm/dd/yyyy) Screener's Name: _____ Screener's Contact: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity: <input type="checkbox"/> Not Hispanic, Latino, Spanish <input type="checkbox"/> Mexican, Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another (Print Origin): _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black, African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other (Print): _____	MFP Target Population (Check one box): <input type="checkbox"/> OA-Older Adult (65+) <input type="checkbox"/> PD-Physical Disability <input type="checkbox"/> TBI-Traumatic Brain Injury <input type="checkbox"/> DD-Developmental Disability	Primary Disability (Check only one): <input type="checkbox"/> D1-Cognitive (TBI, DD, dementia) <input type="checkbox"/> D2-Hearing (deaf/HoH/H loss) <input type="checkbox"/> D3- Mental/SPMI <input type="checkbox"/> D4- Physical (mobility, stamina) <input type="checkbox"/> D5- Vision (Blind/Low Vision) <input type="checkbox"/> D6- N/A <input type="checkbox"/> D7- DNK <input type="checkbox"/> D8- Refused
Date of Initial MFP referral: _____ (mm/dd/yyyy) Date of Waiver Referral: _____ (mm/dd/yyyy)	Referral Source: <input type="checkbox"/> RS1-Inpatient Facility <input type="checkbox"/> RS2-MDSQ <input type="checkbox"/> RS3-Self <input type="checkbox"/> RS4-Family Member <input type="checkbox"/> RS5-CIL, LTCO <input type="checkbox"/> RS6-AAA/ADRC <input type="checkbox"/> RS7-Waiver Case Mgr <input type="checkbox"/> RS8-Personal Care Home <input type="checkbox"/> RS9-Assisted Living Facility <input type="checkbox"/> RS10-Legal Representative <input type="checkbox"/> RS11-Other (specify): _____	Waiver Referral: <input type="checkbox"/> CCSP <input type="checkbox"/> SOURCE <input type="checkbox"/> ICWP <input type="checkbox"/> NOW <input type="checkbox"/> COMP <input type="checkbox"/> Other Waiver (specify): _____	Refused/ineligible: <input type="checkbox"/> in NF < 90 days <input type="checkbox"/> no Medicaid <input type="checkbox"/> didn't transition to qualified residence <input type="checkbox"/> didn't cooperate in planning process <input type="checkbox"/> no longer wished to participate <input type="checkbox"/> Other (specify): _____	
Primary Language: <input type="checkbox"/> American Sign 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: _____		

Personal Data:

2. First Name: _____ MI: ___ Last Name: _____

3. Date of Birth (mm/dd/yyyy) _____ SSN: _____--____--____

4. Medicaid # _____ Medicare # _____

5. Inpatient Facility Name: _____

Facility Street Address: _____

City: _____, Zip: _____ County: _____

MFP field personnel note: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via **FTP**.
DCH MFP Transition Screening Form_Revised_011513 Page 1 of 7



Money Follows the Person Transition Screening Form



Participant Name: _____

6. Discharge Planner/Contact: _____ Phone : _____

7. Marital Status: Single Mar Div Widowed Sep Other: _____

(if applicable) Spouse Name and address: _____

8. Are you a veteran? Yes No. Did you serve during wartime? Yes No

9. 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:

10. What were the reasons you entered this facility? _____

11. How long have you lived here at this facility? _____ years _____ months
(Screener note: to qualify for MFP, the person must have resided in the inpatient facility for a minimum of 90 consecutive days, short term rehab stays do not count).

(Screener note: At this point in the screening interview, introduce, review and obtain signature on *Authorization for Release of Information and Informed Consent for MFP*).

12. Do you have any family living in this area? Yes No

If yes, list name, phone number and address:

13. Are there family member(s) or friend(s) that would be interested in your move to the community? Yes No

14. May we contact these family member(s) or friends(s) to meet with you and us to discuss your move to the community? Yes No

If yes, please provide their name(s) and telephone number(s): _____



Money Follows the Person Transition Screening Form



Participant Name: _____

Housing Section:

15. Where did you live before you came here? _____

(Screener note: after the person answers, code the response by checking the box below:
 01-own home, 02-family home, 03-apt/house leased by participant, 04-apt leased/assisted living, 05-group home/PCH, 06-Other (specify) _____

16. What Georgia County did you live in before you came here? _____

17. Do you want to return to (living situation in Q15)? Yes No

18. If yes, what prevents you from returning to (living situation in Q15)? _____

19. Do you have a home to move back into? Yes No

If yes, the address (street, city, zip, county) of your home: _____

20. If applicable, does anyone live in your home? Yes No

If yes, what are their names and relationship to you? _____

(Screener note: discuss MFP qualified housing. 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 qualified housing.

21. Which type of qualified housing are you interested in and why? _____

(Screener note: after the person answers, code the response by checking the box below:
 01-own home, 02-family home, 03-apt/house leased by participant, 04-apt leased/assisted living, 05-group home/PCH, 06-Other (specify) _____

22. What Georgia County do you prefer to live in? _____

23. Do you have someone you want to live with? Yes No

If yes, list contact information _____

Waiver Service History:

24. Did you receive services in your home before coming here? Yes No

If yes, what services: _____

25. Are you currently on a waiver waiting list for home & community based services?

Yes No If so, which waiver? _____

26. 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? _____



Money Follows the Person Transition Screening Form



Participant Name: _____

Financial Data:

(Screener note: Review facility records to obtain or confirm this information. The signed informed consent will allow you to obtain and review facility records).

25. Income and Resources:

SOURCE	MONTHLY AMOUNT	PAYEE
<input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> SS Retirement		
PENSION BENEFITS		
TRUST PROCEEDS		
INHERITANCE		
VETERAN'S COMPENSATION		
CASH		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
SAVINGS ACCOUNT (DESIGNATED BURIAL)		
CEMETERY PLOT		
RAILROAD RETIREMENT		
LIFE INSURANCE		
CERTIFICATE OF DEPOSIT		
OTHER (SPECIFY)		



Money Follows the Person Transition Screening Form



Participant Name: _____

27. Who is paying for your stay here? _____

26. Are you Medicaid eligible, but subject to transfer of asset penalty?
 Yes No DNK (Do Not Know) (Screener note: check facility records)

Health Care Needs:

27. How would you describe your primary disability or limitation? _____

Screener note: After the person provides a primary disability, confirm that the response fits into one of the following categories and check the box: D1- Cognitive (TBI/DD, dementia), D2- Hearing (Deaf/HoH/Hearing loss), D3- Mental/SPMI, D4- Physical (Mobility/Dexterity/Stamina), D5- Vision (Blind/Low Vision), D6- Not Applicable, D7- DNK, D8- Refused

28. Who is your doctor here at this facility? _____

29. Do you have a primary care doctor or clinic in the community? Yes No

If yes, list contact information? _____

30. Do you need help taking your daily medications? Yes No

Describe assistance needed: _____

31. What specialized medical equipment (DME) and assistive technology devices do you use?

32. Which equipment or devices need to be obtained because you don't own them or they need to be replaced?



Money Follows the Person Transition Screening Form



Participant Name: _____

34. Functional Needs -

See KEY below for instructions to complete:

Function: Ask, "Do you need help with (activities below)? (observe person doing activity when possible)"	Impairment: If assistance needed, check yes	Unmet Need: Ask: Do you have an unmet need for help with (activities) _____ in the community?	Comments: Identify sources of assistance in the community, 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. Continence	<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 Ask: Do you need help with (activities listed above #1-15)? When appropriate, observe the person in the activity.		Unmet Need for Care - when person returns to the community Ask: When you return to the community, do you have an unmet need for 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.	

MFP field personnel note: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via **FTP**.
 DCH MFP Transition Screening Form_Revised_011513 Page 6 of 7



Money Follows the Person 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)
 - NOW/COMP Waiver (Regional DBHDD or DBHDD-DDD/MFP 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. I DO NOT wish to participate in MFP:

Signed: _____ Date: _____

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 Informed 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 face-sheet
- Other (Specify) _____

Notes: _____

MFP Field Personal Contact Information

Name: _____ Date: _____

Phone: _____ Email: _____

MFP field personnel note: the *MFP Transition Screening Form* must be submitted even when the person being screened refuses participation or is found to be ineligible. If the person refuses participation, be sure Question 39 is signed.

MFP field personnel note: All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via **FTP**.
DCH MFP Transition Screening Form_Revised_011513 Page 7 of 7



MFP Vendor Payment Request



MFP Services Rendered for:

Participant Name:	Participant/Contact Phone:
Participant Address:	Participant City /Zip /County

MFP Field Personnel Complete:	
Participant Medicaid ID#:	Participant Date of Birth:
Discharge Date:	Anticipated MFP End Date:

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 TRANSITION SERVICES

Description of Services	Billed Amount
Total Check Amount	

By signing this form, I attest that services were delivered/received consistent with the Individualized Transition Plans (ITPs) or Person Centered Description and MFP Authorization for Services. I understand that Medicaid is the payer of last resort.

MFP Participant Signature

Date

Vendor Signature

Date

Fax or mail to MFP Field Personnel (Print Name): _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Vendor note: send this completed form, signed by participant (or legal guardian), along with invoice and receipts to MFP field personnel listed above by fax, mail or via file transfer protocol (FTP).

MFP Field Personnel note: once verified, send this completed form along with invoice and receipts to the Fiscal Intermediary by **FTP**. Send this completed form and required documentation to the DCH MFP office by **FTP**.