

SECTION
CASE MANAGEMENT SYSTEM

SUBJECT
Case Management Team Requirements

TEAM COMPOSITION

Case Management Teams consist of the following:

- A Registered Nurse licensed to practice in the State of Montana;
- A Social Worker;
- Appropriate support staff; and
- Staff must be sufficient to appropriately meet the needs of the CMTs SDMI HCBS individuals.

TEAM MEMBER REQUIREMENTS

1. The registered nurse must:
 - a. Have a Bachelor's Degree in nursing and three years of professional nursing experience, plus two years of long-term care experience and be licensed to practice in the State of Montana. Any request for an exception to this requirement must be made in writing to the department;
 - b. Have knowledge of case management methods, procedures and practices;
 - c. Have knowledge of the application of diagnostic and crisis intervention skills;
 - d. Have knowledge of the problems and needs of long-term care individuals; and
 - e. Have the ability to:
 - Promote the individual's self-determination;
 - Assess the individual needs;
 - Develop and implement individual Person-Centered Recovery Plan which reflects the services the individual has identified as most appropriate to meet their needs and fits within specified cost limits;
 - Monitor service delivery including cost of services provided;
 - Evaluate service effectiveness;

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- Re-assess continuing individual need; and
 - Provide guidance to assist individuals in utilizing services effectively and appropriately.
2. The social worker must have:
- a. A Bachelor's Degree in social work or a related behavioral science and one-year experience in a health care setting. Any request for an exception to this requirement must be made in writing to the Department.
 - b. Knowledge of case management methods, procedures and practices;
 - c. Knowledge of the application of diagnostic and crisis intervention skills;
 - d. Knowledge of the problems and needs of long-term care individuals; and
 - e. The ability to:
 - Promote the individual's self-determination;
 - Assess the individual needs;
 - Provide input into the Person-Centered Recovery Plan with respect to social and other non-medical covered services;
 - Monitor service delivery including cost of services provided;
 - Evaluate service effectiveness;
 - Re-assess continuing individual need;
 - Provide guidance to assist individuals in utilizing community services effectively and appropriately; and
 - Identify and participate in the development or improvement of community resources as related to finding alternatives for long-term care and promoting community accessibility for individuals.

