MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

BIG SKY WAIVER **Policy Manual**	**Section: PERSON CENTERED PLANNING**
	Subject: Person-Centered Planning Re-Admission to CFC/PAS

Reference: 37.40.1005, 37.40.1114

PURPOSE

Re-admissions must be done to ensure that the required paperwork and coordination of services is completed prior to the delivery of services.

Re-admissions occur in one of the following scenarios:

1. The member is discharged from Community First Choice/Personal Assistance Services (CFC/PAS), remains on waiver, and is re-admitted to CFC/PAS;

2. The member is discharged from waiver, remains on CFC/PAS, and is re-admitted to waiver; or

3. The member is discharged from waiver and CFC/PAS and is re-admitted to wavier and CFC/PAS at the same time.

Re-admissions must be done to ensure that the required paperwork and coordination of services is completed prior to the delivery of services.

PROCEDURE

1. Scenario One: The member is discharged from CFC/PAS, remains on waiver, and is re-admitted to CFC/PAS.

    a. The provider agency must contact the case manager to notify them that they intend to initiate CFC/PAS services and to determine the month of the case manager annual person centered planning meeting.

    b. CFC/Provider requests a copy of the Person Centered Planning (PCP) form (SLTC-200) from the Case Manager Plan Facilitator. The provider agency and Plan Facilitator must determine if the CFC/PAS PCP form has expired.

        i. If the CFC/PAS PCP form is less than a year old it has not expired and the Plan Facilitator does not need to take

any action as part of the CFC/PAS re-admission.

ii. If the CFC/PAS PCP form has expired (i.e. is more than a year old) the case manager must update the PCP form as part of the member's intake to CFC/PAS. The provider agency and plan facilitator have the options for completing the CFC/PAS PCP process and update the CFC/PAS PCP form. The Case Manager Plan Facilitator should contact the member to discuss the options and obtain the member's preference.

NOTE: The provider agency and Plan Facilitator should document the member's preference for the option that is selected prior to implementing that option.

a. Option 1: The member, provider and case manager have the option of conducting a coordinated in-person PCP meeting to complete the PCP form (SLTC 200) and implement the readmission to CFC/PAS. If this option is selected the next coordinated CFC/PAS PCP visit will take place at the next waiver annual PCP meeting.

b. Option 2: The member, provider and case manager have the option of coordinating the PCP process with the member over the phone. If option 2 is selected the case manager has 10 working days from the date of CFC/PAS re-admission intake to complete the PCP form over the phone with the member. The case manager must obtain the required PCP form signatures (provider and member) within 30 days of the member beginning CFC/PAS services. If option 2 is selected a coordinated PCP in-person meeting must occur within six months of the member readmitting to CFC/PAS services. This can be done at the member's next case management visit.

c. When a member has been off of CFC/PAS services for more than 45 days the CFC/PAS agency must complete a new intake as part of re-admission to CFC/PAS. The intake requires the CFC/PAS provider to complete an on-site intake visit and complete a new CFC/PAS Service Plan. The CFC/PAS Service Plan must be signed by the member, provider, and Plan Facilitator. The provider has 30 days from the date of the

CFC/PAS re-admission intake visit to obtain the Plan Facilitator signature and distribute copies of the CFC/PAS Service Plan.

2. Scenario Two: The consumer is discharged from waiver, remains on CFC/PAS, and is re-admitted to waiver.

   a. The case manager and CFC/PAS provider must complete the steps outlined in the Plan Facilitator Transition policy (Refer to CSB 1109).

3. Scenario Three: The member is discharged from waiver and CFC/PAS and is re-admitted to wavier and CFC/PAS at the same time.

   a. The case manager completes waiver re-admission process and paperwork according to waiver re-admission policy.

   b. The CFC/PAS provider completes the re-admission process and paperwork according to CFC/PAS policy.

   c. The Case Manager Plan Facilitator contacts MPQH by phone to notify them of the plan for re-admission and to determine whether the member has been referred for re-admission to CFC/PAS.

      i. If the member needs CFC/PAS and the re-admission referral has not be completed the case manager should contact the CFC/PAS provider to discuss re-admission. If the case manager doesn't know the CFC/PAS provider the case manager should make a referral for CFC/PAS to MPQH.

      ii. The member, Case Manager Plan Facilitator and CFC/PAS provider decide whether to conduct a coordinated re-admission visit for waiver and CFC/PAS services to complete the PCP process.

      iii. The provider agency and plan facilitator have two options for completing the CFC/PAS PCP process. The Case Manager Plan Facilitator should contact the member to discuss the options and obtain the member's preference.

         NOTE: The provider agency and Plan Facilitator should document the member's preference for the option that is selected prior to implementing that option.

a. Option 1: The member, provider and Case Manager Plan Facilitator have the option of conducting a coordinated re-admission visit to complete the CFC/PAS PCP form, CFC/PAS Service Plan and any additional paperwork. If this option is selected the next coordinated visit will occur at the member's annual person centered planning meeting.

b. Option 2: The member, provider and Case Manager Plan Facilitator have the option of coordinating the PCP process with the member over the phone. If option 2 is selected the case manager must complete the PCP form during the waiver admit visit. The Case Manager Plan Facilitator must obtain the required form signatures (provider and member) within 30 days of the admit visit with the member. If option 2 is selected a coordinated meeting must occur within six months of the member beginning CFC/PAS services. This can be done at the member's next case management visit.