MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**Addictive and Mental Disorders Division** Severe and Disabling Mental Illness, Home and Community Based Services Waiver Manual
	Date effective: July 1, 2020 **Date revised:**
Policy Number: *SDMI HCBS 420*	**Subject:** Case Transitions

General Requirements

(1) The case management team (CMT) may change a member's classification or transfer cases when a member:

(a) moves to a new service area or chooses a different case management team (CMT);

(b) transfers to the SDMI HCBS Waiver from the Big Sky Waiver or the HCBS Waiver for Individuals with Developmental Disabilities (0208 Comprehensive Waiver);

(c) transfers from the SDMI HCBS Waiver to the Big Sky Waiver or the HCBS Waiver for Individuals with Developmental Disabilities (0208 Comprehensive Waiver); or

(d) transitions from the Montana State Hospital (MSH).

Transfer Procedures

(1) When a member chooses a different CMT:

(a) the sending CMT must fax a Discharge Sheet (DPHHS-AMDD-137) to Mountain Pacific Quality Health (MPQH) and circle "other" and specify the member has chosen a different CMT, the date of referral is the discharge date from the sending team; and

(b) the receiving CMT must fax an Intake Sheet (DPHHS-AMDD-136) to MPQH. The admit date is the first day the member receives case management from the new CMT.

(2) The DPHHS-DD/SLTC-55 form DOES NOT get sent to the county Office of Public Assistance (OPA).

(3) If the transferring member is changing care categories, the referring CMT must request availability of that type of care.

Transferring Members to/from other Waivers

(1) The department must authorize the transfer if a member would like to transfer between any of the following waivers:

(a) SDMI HCBS waiver

(b) Big Sky waiver;

(c) 0208 Comprehensive waiver.

(2) The current waiver team must make a prior authorization request through the care management system.

(3) Once authorized, the transferring CMT:

(a) makes a referral to the receiving CMT in the new service area;

(b) discusses transfer choice with the member or legal representative. Service coordination can be facilitated more easily with the transfer of records;

(c) informs the member or legal representative to notify Social Security office regarding change of address so that benefits can be forwarded;

(d) identifies the member's current needs for the receiving CMT so providers are located before the member moves. The coordination with the receiving CMT is imperative to ensure a smooth transition for the member. Some services, such as medications must be coordinated to provide adequate care for the transferring member. Communication between the CMTs is necessary to facilitate the transition; and

(e) upon discharge, fax Discharge Sheet (DPHHS-AMDD-137) to MPQH and notify providers.

(4) The receiving CMT must:

(a) make arrangement to discuss service needs with the member or legal representative and referring CMT. This can be done via the telephone if travel is a problem, or the transferring CMT can arrange for the member to visit the receiving CMT by working with the member's family or authorizing supervision and mileage;

(b) inform the member of all available providers in the area to allow the member a choice. If this is done over the telephone, the receiving CMT shall send a list of available providers to the member and ask the member to select providers for each designated service and inform CMT. Many teams use a freedom of choice checklist form. The transferring CMT can assist the member with this form, if necessary;

(c) make referrals to the providers the member chooses;

(d) remind the member or legal representative to notify Social Security office regarding change of address so that benefits can be forwarded; and

(e) fax intake sheet (DPHHS-AMDD- 136) to MPQH.

Transferring from the Montana State Hospital to SDMI HCBS Waiver

(1) Members transferring from the MSH to the community have the choice of:

(a) where they are discharged to;

(b) who they choose as a provider; and

(c) what type of treatment they choose to receive.

(2) When a member is transferring from the MSH to the SDMI HCBS waiver, the receiving team's role is to assist the state hospital with the transfer. This includes:

(a) assisting with locating providers;

(b) assisting with locating housing/facility;

(c) referring to community resources; and

(d) other assistance as communicated by the department or MSH.

(4) The MSH must:

(a) set up all appointments necessary in the community the member is being discharged to base on current medications being prescribed, as appropriate;

(b) fax a copy of the medication list and discharge instructions to the current medical provider and/or assisted living provider and the CMT; and

(c) dispense five days of prescribed medication at the time of discharge.

(5) CMTs must communicate with the discharging social worker from the MSH to request documentation that is needed in order to insure a smooth transition to the community.

Re-Enrollment

(1) The CMT is required to complete a new Person-Centered Recovery Plan with a new service plan date span if a member has been discharged from the SDMI HCBS waiver due to a short-term admission to:

(a) a hospital;

(b) a nursing facility;

(c) an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);

(d) an Institution for Mental Disease (IMD);

(e) an extended absence and the CMT is holding the member's slot open; or

(f) if there has been a significant change in the member's condition, the CMT is required to complete a new Person-Centered Recovery Plan with a new service plan date span.