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GENERAL REQUIREMENTS

There are occasions for changing a member's classification or transferring cases:

- A member moves to a new service area or chooses a different case management team (CMT);
- A member transfers to the SDMI HCBS Waiver;
- A member transfers from the SDMI HCBS Waiver to the Big Sky Waiver or the HCBS Waiver for Individuals with Developmental Disabilities (0208 Comprehensive Waiver); or
- Transitions from the Montana State Hospital (MSH).

TRANSFER PROCEDURES

When a member chooses a different CMT, the sending CMT must fax a Discharge Sheet (DPHHS-SLTC-137) to Mountain Pacific Quality Health (MPQH) and circle "other" and specify the member has chosen a different CMT. The receiving CMT must fax an Intake Sheet (DPHHS-SLTC-136) to MPQH. The admit date is the first day the member receives case management from the new CMT. The date of referral is the discharge date from the sending team.

Do not send a DPHHS-DD/SLTC-55 form to the county Office of Public Assistance (OPA).

CHANGING CARE CATEGORIES WITH TRANSFER

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

If a member would like to transfer from the SDMI HCBS Waiver to Big Sky Waiver or DD0208 waiver, this must be prior authorized by central office.

If a member would like to transfer from the Big Sky Waiver or DD0208 waiver to the SDMI HCBS Waver, this must be prior authorized by central office.

The current waiver team must make a prior authorization request through their Community Program Officer through CaseWave.

TRANSFERRING CASE MANAGEMENT TEAM

- Make a referral to the receiving CMT in the new service area.
- Discuss transfer choice with the member or legal representative. Service coordination can be facilitated more easily with the transfer of records.
- Inform the member or legal representative to notify Social Security office regarding change

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of address so that benefits can be forwarded.
- Identify 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.
- Upon discharge, fax Discharge Sheet (DPHHS-SLTC-137) to MPQH and notify providers.

RECEIVING CASE MANAGEMENT TEAM
- Arrangements must be made 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.
- When discussing service delivery, the receiving CMT must 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.
- When the member has selected the potential providers, CMT can make referrals to those providers.
- Remind the member or legal representative to notify Social Security office regarding change of address so that benefits can be forwarded.
- Fax intake sheet (DPHHS-SLTC- 136) to MPQH.

TRANSFERING FROM THE MONTANA STATE HOSPITAL TO SDMI HCBS **WAIVER**
Member transferring from the MSH to the community have freedom of choice; the same freedom of choice that is offered in the SDMI HCBS Waiver. Members have the choice of where they are discharged to, who they choose as a provider and what type of treatment they choose to receive. Members leaving the MSH can refuse any recommended services except when court ordered by a Judge.

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 could include but is not limited to:
- Assisting with locating providers;
- Assisting with locating housing/facility; and

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- Refer to community resources.

The MSH will:

- Set up all appointments necessary in the community the member is being discharged to base on current medications being prescribed;
    - If a member is not currently being prescribed anti-psychotropic medications, a psychologist appointment will not be set up.
- Fax a copy of the medication list and discharge instructions to the current medical provider and/or assisted living provider.
    - The CMT can contact the discharging social worker at the MSH for a copy of the discharge instructions.
- Dispense five days of prescribed medication at the time of discharge.

CMTs are encouraged to 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.

If a receiving CMT has concerns the SDMI HCBS Waiver is not an appropriate placement for a member, contact your Community Program Officer.