# Senior & Long Term Care Division
## Community Services Bureau
Big Sky Waiver Policy Manual

**Title:** BSW 808
**Section:** CASE MANAGEMENT SYSTEM
**Subject:** **Member Transfer or Change of Classification**
**Reference:** Big Sky Waiver Application (01-01-2018)
**Supersedes:** BSW 808 (01/01/2012)

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### GENERAL REQUIREMENTS

Member transfer or change of classification include the following four categories:

1. Member transfers to a new case management team (CMT);
2. Member transfers to another Medicaid program;
3. Member transfers to the Big Sky Waiver – Big Sky Bonanza option; or
4. Member transfers to another care category.

### MEMBER - CMT CHANGE

When a member chooses a different CMT, the sending CMT must fax a Discharge Sheet (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 (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. When members port their services, the sending CMT should arrange for the return of their slot from the receiving CMT in writing. Send CSB notification of the change in teams.

### TRANSFERRING CMT PROCEDURES

1. Make a referral to the receiving case management team or teams (if there is more than one) in the new service area. Ask the receiving CMT about slot availability. If the receiving CMT does not have a slot, the member’s slot will be transferred to the receiving team until that team has an opening. As soon as the receiving team has a similar slot open (e.g., basic, AR, supported living), the slot will be

returned to the transferring CMT. Exchange of slots should be done in writing via memos/email.

2. Discuss transfer choice with the member or legal representative. Service coordination can be facilitated more easily with the transfer of records.
3. Inform the member or legal representative to notify the local OPA and Social Security office regarding change of address so that benefits can be forwarded. CMT can assist with these tasks if the member is unable.
4. Help identify the member's current needs for the receiving CMT so that they can try to locate providers before the member moves. Coordinate with the receiving CMT to ensure a smooth transition.
5. Upon discharge, fax Discharge Sheet (SLTC-137) to MPQH and notify providers.

**RECEIVING CMT PROCEDURES**

1. After obtaining the modified or current level of care screen, make arrangements 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 help make arrangements 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 particular 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.
2. When the member has selected the potential providers, CMT can make referrals to those providers.
3. Notify the local OPA via e-mail, if the member chooses to transfer their Medicaid, and the local Social Security Office regarding incoming transfer of case.

Once the member moves, follow through to see whether benefits have been transferred.

4. Fax intake sheet (SLTC- 136) to MPQH.
5. Document in the Progress Notes, a Referral Summary, describing the transferal process.
6. Upon transfer of the records, the nurse and social worker must make a home visit to assess level of services within 30 days. Amend the Service Plan (SP) if necessary and remind the member or legal representative to obtain a local primary care provider.
7. Within 90 days, or before the annual SP expires, develop a new SP for the current services. The social worker can use the former psychosocial summary, but at the time of the new SP, it should be updated to reflect any changes.

**MEMBER - PROGRAM CHANGE**

All applicants requesting BSW coverage are required to meet the same criteria regardless if the applicant has previously received coverage under another Medicaid program. Applicants do not automatically meet BSW criteria by gaining eligibility under another Medicaid program. Applicants do not transfer from one Medicaid program to BSW; applicants discharged from one Medicaid program are required to apply and meet eligibility requirements for the BSW program.

**MEMBER-TRANSFER BSW – BIG SKY BONANZA OPTION**

1. Notify RPO if a member expresses interest in the Bonanza option.
2. Upon request, provide a copy of the SP to the RPO.
3. Coordinate transfer to Bonanza option with the BSB RPO. Upon verifying date of enrollment CMT must fax a Discharge Sheet (SLTC-137) to MPQH and specify that the member is converting to the Bonanza option. The date of discharge should be the day prior to enrollment in Bonanza. The BSB RPO will submit a new intake sheet (SLTC-233) to MPQH.
4. Transfer the following “Record Set” to the BSB RPO:

a) Current Level of Care Screening Determination (SLTC 61).

b) Copy of the Level of Care Screen.

c) Level I (SLTC-145) and if applicable, a copy of the Level II report.

d) Entrance into Medicaid/Discharge (SLTC-55) (Do not close SLTC-55).

e) Any other documents relevant to the member's care.

**MEMBER - CATEGORY CHANGE**

If the transferring member is changing care categories, the referring CMT must request availability of that type of slot. For a member in a basic slot who needs supported living services upon transfer, the referring CMT should contact the Community Services Bureau (CSB) to apply for a supported living slot. For a member in a supported living who needs a basic slot upon transfer, the member can take the supported living slot to the new service area and obtain basic services. This will still be counted as a supported living slot even though the level of services may be the same as a basic slot. As soon as the new basic slot opens (Physically Disabled for those under 65, Elderly for those over 65 years), the member will take that slot, and the supported living slot will be returned to Helena via a memo/email.