Title: **New Admissions**

Section: **ELIGIBILITY FOR SERVICES**

Subject: **SD-CFC/PAS 411**

Reference: **ARM 37.40.1005 and ARM 37.40.1114**

DEFINITION This policy outlines the referral process and initial admission for individuals who are new to the Self-Directed (SD) Community First Choice/Personal Assistance Services (CFC/PAS) program. For high risk intakes refer to SD-CFC/PAS 414.

REFERRAL SOURCE PROCEDURE

1. Referral source collects as much of the following data as possible from the individual/ family member:

    a. Name, date of birth, address, phone number, Medicaid identification number (when known), responsible party/Personal Representative (PR), health care professional, diagnosis, synopsis of need, involvement with other services, and other relevant information.

    b. If the referral source is a CFC/PAS provider agency the following applies:

        i. Provider agency determines whether the individual meets the policy/criteria for CFC/PAS:

            1. If the individual does not meet criteria for CFC/PAS (does not require help with activities of daily living, is not Medicaid eligible, lives in a group home etc.) and the individual agrees that they do not meet policy/criteria for CFC/PAS, the referral process ends.

            2. If the individual disagrees with the provider agency determination that they

do not meet the CFC/PAS criteria and the individual is Medicaid eligible, the provider agency transmits the Referral form (SLTC-154), to Mountain Pacific Quality Health (MPQH) and documents the reason they believe the individual is not eligible. MPQH verifies the reason for ineligibility and notifies the individual of their ineligibility, provides fair hearing rights, and enters reason for denial in database.

3. If the individual meets the criteria for CFC/PAS the provider agency transmits Referral (SLTC-154) to MPQH via fax within one working day. If the provider agency is uncertain whether a member will qualify for CFC/PAS the provider agency should submit the request and let MPQH complete the referral.

MPQH REFERRAL PROCEDURE

1. MPQH inputs information from referral into their database, checks Medicaid financial eligibility, and provides basic information on the CFC/PAS program to the member. MPQH will not process the referral until Medicaid eligibility is determined.

2. Once Medicaid eligibility is confirmed, MPQH assigns referral information to the MPQH nurse coordinator.

3. MPQH nurse coordinator completes an onsite review within 10 working days of MPQH receiving the referral.

   NOTE: If the onsite review cannot be completed within 10 working days, a pre-screen will be completed (refer to the Pre-Screen section, pgs. 6-7 below).

4. MPQH completes level of care assessment within 10 working days of receiving the referral. If the member has an

intellectual disability and MPQH is unable to determine level of care, MPQH will make a referral to the Developmental Disability Regional Office.

5. ➢MPQH nurse completes the onsite visit and member assessment and authorization. MPQH inputs information into database and faxes Member Overview, Service Profile, and Capacity Assessment (SLTC-154/155) to the provider agency and the Plan Facilitator.

   a. The Service Profile identifies the name of the CFC/PAS provider agency, Personal Emergency Response System (PERS) agency, and Plan Facilitator provider agency.

6. ➢MPQH sends the CFC/PAS Services Authorization notice to the member (SLTC-151).

   ➢NOTE: MPQH does not send the Service Profile to the member. The provider agency is responsible for providing the member with a copy.

➢PROVIDER AGENCY REFERRAL INTAKE PROCEDURE

Provider agency receives the referral from MPQH and has 10 working days to complete an intake visit with the member or submit the Unable to Admit/Discharge form (SLTC-158) to MPQH.

1. Provider agency Program Oversight staff and the member meet in-person in the member's home to complete the intake visit. Refer to CFC/PAS 702. If the member has a PR, both the member and the PR must be present in the member's home during the intake visit.

   a. If the provider agency is the Plan Facilitator, the Plan Facilitator must participate at the intake meeting and

complete the Person Centered Planning (PCP) form (SLTC-200). The provider agency Program Oversight staff must complete the Service Plan (SLTC-175) and ensure the Member/PR Agreement (SLTC-159/166) is reviewed and signed.

b. If the case manager is the Plan Facilitator, the provider agency must coordinate with the case manager to ensure that the Plan Facilitator completes the PCP form.

   i. Provider agency must contact the Case Manager Plan Facilitator and inform them that the member is enrolling to CFC/PAS, schedule a coordinated visit (when possible) and determine the month of the annual case management visit.

   ii. Provider agency must use the PCP form to guide the development of the Service Plan. If the provider agency does not have a PCP form when they meet with the member/PR., (i.e. a coordinated visit does not occur) the provider agency must develop the Service Plan according to member preferences and ensure a PCP form is completed.

   iii. Case Manager Plan Facilitator is responsible for completing the CFC/PAS PCP form. The Case Manager Plan Facilitator may complete an in-person on-site coordinated visit with the provider agency or complete the PCP form with the member over the phone. Refer to CSB 1104 and 1107.

c. Provider agency oversight staff must complete the Service Plan with the member/PR and ensure the Member/PR agreement is reviewed and signed.

   i. If the Case Manager Plan Facilitator is not present at the agency's intake visit, the agency

must obtain the Plan Facilitator's signature on the Service Plan within 10 working days of completing the intake and distribute the form to the member and Plan Facilitator within 30 days.

d. ➢Provider agency educates the member/PR regarding program parameters and expectations.

i. ➢Provider agency reviews the Health Care Professional (HCP) Authorization form (SLTC-160) with the member/PR and instructs them to obtain HCP approval on the HCP form prior to beginning services. Refer to SD-CFC/PAS 418.

ii. Member/PR completes the HCP form and returns it to the provider agency prior to the implementation of services.

e. Provider agency has ten days to submit the Agency Admit form (SLTC-163) to MPQH after the in-person intake visit. Provider agency provides the member and the member's Plan Facilitator with a copy of the Admit form.

f. Provider agency begins attendant services as soon as possible after insuring all necessary documents are completed.

i. If the provider agency cannot begin services within a reasonable amount of time after the intake visit, the agency should follow-up with the member and document the reason for the delay in delivering services. The member has the option of switching agencies, discharging from services, or staying with the current agency.

1. If the member elects to switch agencies, the member must contact other agencies to determine whether another agency can serve them. The provider

agency must follow the Request to Change Agency policy (Refer to CFC/PAS 412).

2. If the member elects to discharge from services, the provider agency must discharge the member. Refer to CFC/PAS 705.

3. If the member elects to stay with the current agency, the agency has up to 45 days from the date of the intake visit to serve the member. If the agency cannot serve the member within 45 days the agency must discharge the member.

4. When the provider agency discharges the member (scenario 2 and 3 above), the provider agency must submit the Unable to Admit/ Discharge form to MPQH within ten days and follow the discharge policy. Refer to CFC/PAS 705.

PRE-SCREEN

1. ➢If a MPQH nurse coordinator's travel schedule does not allow for an onsite review within 10 working days of receiving the referral, the MPQH nurse may pre-screen the member over the phone. A phone pre-screen review must be completed within 10 working days of MPQH receiving the referral.

2. ➢MPQH pre-screen review includes the following member assessment:

   a. ➢MPQH nurse assessment, which includes demographic information, review of member's service needs, initial authorization of CFC/PAS service hours, authorization of days per week by task, capacity screen, and documentation of member's choice of agency. During the pre-screen authorization the

MPQH nurse will schedule the mandatory on-site visit, which must be completed within 30 working days of MPQH receiving the referral.

b. Pre-screen review includes the initial determination of level of care.

i. ➢If level of care cannot be determined during the MPQH nurse pre-screen, a referral will be made to MPQH for a full level of care screen. If level of care cannot be determined within 10 working days of receiving the referral, MPQH will default the member to the personal assistance program until the level of care can be determined.

ii. If level of care can be determined within 10 working days, MPQH will include the determination of level of care and program option type (i.e. CFC or PAS) on the Pre-Screen Service Profile.

3. Upon completion of the pre-screen, MPQH provides a copy of Page 1 of the Referral/Overview and a Pre-Screen Service Profile to the member's provider agency and Plan Facilitator.

a. MPQH will notify the originating referral agency if the member selects a change in provider agency after a high risk intake has occurred. (Refer to SD-CFC/PAS 414).

4. Upon completion of the on-site visit, MPQH provides a complete Overview and Service Profile to the provider agency and Plan Facilitator.

a. If the Service Profile authorization is different than the Pre-Screen Service profile authorization, the provider agency has 10 working days to implement the new authorization and complete an amendment.