FOOTHILLS GATEWAY, INC.

Referral for Provider in Supported Living Services (SLS) and Children's Extensive Services (CES)

PROCEDURE:

- The Placement Coordinator will keep track of the SLS/CES admissions in a tracking system.
- Using the updated list of people waiting to enroll into SLS/CES, the Placement Coordinator will identify the next person to be offered services and will contact the assigned Case Manager.
- Services will be **offered** once financial eligibility is verified, SIS and 100.2 is completed. Case Manager will notify Placement Coordinator when completed. Placement Coordinator will fill out offer form and send to Case Manager but **admission** to services is dependent upon completion of all steps in the RFP procedure.
- The assigned Case Manager will contact the individual and/or family.
  - If services are accepted, an initial meeting will be arranged between the individual/family and the Case Manager.
  - If (SLS only) services are accepted, the Case manager will verify if a Supports Intensity Scale (SIS) assessment has been completed or request a SIS to be completed.
  - If services are refused or accepted, this is noted on the Documentation of SLS/CES Consideration form and returned to the Placement Coordinator. The individual will remain on the Master List according to their Order of Selection date.
    - A change of Waiting List form will be filled out by Case Manager with the change of timeline.
    - Manual Waiting List and CCMS will be updated.

<u>**Eligibility Steps**</u>

An Initial Meeting will be held for the purpose of completing the Medicaid and Long Term Care Eligibility forms.

1. The Case Manager will determine if the Disability Determination Services (DDS) application is needed and will complete as necessary, copy and send.
2. The Case Manager will assist the individual/family to complete the Medicaid Application.
3. The individual/family will be asked to provide supporting documentation for the Medicaid Application, such as bank statements, birth certificate, and rent receipts, as applicable.
4. The Medicaid Application will be copied and sent along with supporting documentation to the Larimer County Department of Human Services.
5. The Case Manager will complete the LTC 100.2 on the Benefits Utilization System (BUS) after obtaining information from the individual/family.
6. A Professional Medical Information Page (PMIP) will be sent to the person's physician for a signature.

<u>**Needs and Services Identification**</u>

A follow up meeting will be held to identify needs, set priorities, and begin selecting a provider. If State SLS services are being offered, this will be the initial meeting.

1. The Referral for Provider (RFP) procedure and packet will be reviewed with the individual/family.

2. The Case Manager will prepare an Individual Profile to be sent to all providers. The profile will provide a contact name and phone number, general information about the person, their needs and potential services without disclosing Personal Health Information (PHI). A release of information will be signed at this time. This will give permission to send the Individual Profile out to either ALL PASAs/Home Health Care Agency (HHCA) or the family/individual can select certain PASAs/HHCA to release information to.
3. The Placement Coordinator will review the Individual Profile and send an e-mail to all providers.
4. The individual PASAs or HHCA can use the e-mail information to ask the Case Manager any questions, contact the person and share information about their agency, staff, and method of service provision.
5. If an individual/family is interested in working with only a specific agency or provider, or if they wish to not use the e-mail process, they can use the RFP book and contact possible providers independently.
6. If the individual/family is interested in waiving the RFP process, an RFP waiver must be signed.
7. The Case Manager may assist the individual/family to identify the specific PASA or HHCA to contact.

<u>Individual and/or Family Responsibilities</u>

1. The individual/family will contact or receive contact from potential PASAs or HHCAs. The individual/family may choose to interview, ask specific questions, and/or meet the staff.
2. The individual/family will share with the prospective PASA or HHCA what the desired supports and services are that the person enrolling into SLS/CES needs/wants.
3. The individual/family will select and notify the PASA or HHCA and the Case Manager of his/her choice.
4. The individual/family may decide to select more than one PASA or HHCA, if desired, to meet the needs.
5. A follow-up e-mail will be sent to all providers once the individual/family has selected a PASA or HHCA, notifying everyone that the RFP is now closed.
6. For State funded SLS only, Resource Allocation Committee (RAC) will approve/review the plan of service.

<u>Case Manager Responsibilities</u>

1. The Case Manager will call the individual/family each week to see if a PASA or HHAC has been selected and to offer assistance, if needed.
    a. The Case Manager may set a timeline as needed.
    b. Individuals with Long Term Care Medicaid eligibility completed, and a PASA or HHCA selected will be admitted to services.
2. Once providers have been selected the Case Manager will send information packets to all selected service providers. The information packets will be put together by the Master File Clerk using the individual file Information Request form.
3. The Case Manager will work with the Resource Coordination Assistant to:
    a) Verify Long Term Care financial eligibility.
    b) If necessary, request a TPQY (query verifying benefits) from the Social Security office to verify the amount and type of Social Security benefits.
    c) Complete and send a County Notification form to the Larimer County Department of Human Services.

4. The Case Manager will schedule and facilitate a Service Plan (SP) meeting with the Interdisciplinary Team (IDT) consisting of the individual/family, Service Agency representative(s), and new Case Manager.
5. The Case Manager will send Placement Coordinator the date services will start, what PASA(s) are providing services and what services the PASA(s) will be providing.

Service Plan (SP) Meeting

1. This will be the Initial SP for the person.
2. The Case Manager and IDT will document and prioritize needs, using the Individual Profile and other Person Centered Tools that were used as reference.
3. Using the SIS assessment level, the IDT will develop a Service Plan within the allowable limits.
4. The Case Manager will complete the Service Plan (SP) and SP coversheet,
5. The IDT will set a start date for the SLS program.

12/03. . . .4/16; 5/17; 6/18