

Volume II: Appendices

MONEY FOLLOWS THE PERSON

OPERATIONAL PROTOCOL

FOR THE

RHODE ISLAND

THE RHODE TO HOME DEMONSTRATION PROJECT

Submitted to: Department of Health and Human Services,

Centers for Medicare and Medicaid Services (CMS)

01/06/2011

APPENDICES

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APPENDIX A

LETTERS OF ENDORSEMENT

Specific Letters to be Inserted

APPENDIX B

MEDICAID NURSING HOMES

Provider Name	Location
<i>Nursing Home</i>	
Alpine Nursing Home	Coventry
Apple Rehab Clipper	Westerly
Apple Rehab Watch Hill	Watch Hill
Avalon Nursing Home	Warwick
Ballou Home for the Aged	Woonsocket
Bannister House	Providence
Bayberry Commons	Pascoag
Berkshire Place	Providence
Bethany Home of RI	Providence
Brentwood Nursing Home	Warwick
Briarcliffe Manor	Johnston
Cedar Crest Nursing and Rehab Centre	Cranston
Charlesgate Nursing Center	Providence
Cherry Hill Manor	Johnston
Chesnut Terrace Nursing and Rehab Center	East Providence
Cortland Place	Greenville
Coventry Center	Coventry
Cra-Mar Meadows	Cranston
Crestwood Nursing and Convalescent Home	Warren
Eastgate Nursing and Recovery Center	East Providence
Elmhurst Extended Care	Providence
Elmwood Health Center	Providence
Emerald Bay	Cumberland
EPOCH Senior Health	Providence
Evergreen House Health Center	East Providence
Forest Farm Health Care Center	Middletown
Friendly Home Inc.	Woonsocket
Golden Crest Nursing Center	North Providence
Grace Barker Nursing Center	Warren
Grand Islander Center	Middletown
Grandview Center	Cumberland
Greenville Center Skilled Nursing and Rehabilitation	Greenville
Greenwood Care and Rehabilitation Center	Warwick
Hallworth House	Providence
Harris Health Care North	Central Falls
Harris Health Center	East Providence
Hattie Ide Chaffee Home	East Providence
Heatherwood Nursing and Rehab Center	Newport
Heberts Nursing Home	Smithfield
Heritage Hills Nursing Centre	Smithfield
Holiday Retirement Home	Manville
Hopkins Manor	North Providence
Jeanne Jugan Residence	Pawtucket
John Clarke Retirement Center	Middletown
Kent Regency	Warwick
Linn Health Care Center	East Providence
Mansion Nursing and Rehab Center	Central Falls
Morgan Health Center	Johnston
Mount St. Francis Health Center	Woonsocket
Mount St. Rita Health Centre	Cumberland

Provider Name	Location
Nancy Ann Nursing Home Inc	Foster
North Bay Manor	Smithfield
Oak Hill Nursing & Rehabilitation Center	Pawtucket
Oakland Grove Health Care Center	Woonsocket
Orchard View Manor Nursing and Rehab Center	East Providence
Overlook Nursing and Rehab Center	Pascoag
Park View Nursing Home	Providence
Pawtucket Skilled Nursing and Rehab	Pawtucket
Pawtucket Village Care and Rehab Center	Warwick
Pinegrove Health Center	Pascoag
Rhode Island Veterans Home	Bristol
Riverview Healthcare Community	Coventry
Roberts Health Centre	North Kingstown
Saint Antoine Residence	North Smithfield
Saint Elizabeth Home	East Greenwich
Saint Elizabeth Manor	Bristol
Sakonnett Bay Retirement	Tiverton
Scalabrini Villa	North Kingstown
Scallop Shell Nursing and Rehab Center	Peace Dale
Scandinavian Home	Cranston
Shady Acres Nursing Facility	West Kingston
Silver Creek Manor	Bristol
South Bay Retirement	South Kingstown
South County Nursing and Subacute Center	North Kingstown
South Kingstown Nursing and Rehab Center	West Kingston
St. Clare Home	Newport
Steere House Nursing and Rehab Center	Providence
Summit Commons	Providence
Sunny View Nursing Home	Warwick
The Clipper Home	Westerly
Tockwotton Home	Providence
The Village at Waterman Lake	Greenville
Village House Nursing and Rehab	Newport
Warren Center	Warren
Watch Hill Care and Rehabilitation	Westerly
Waterview Villa	East Providence
West Shore Health Center	Warwick
West View Health Care Center	West Warwick
Westerly Health Center	Westerly
Westerly Nursing Home Inc.	Westerly
Woodland Convalescent Center	North Smithfield
Woodpecker Hill Health Center	Greene
Woonsocket Health and Rehabilitation Centre	Woonsocket

APPENDIX C

HCBS PROVIDERS

Home Care Agencies

Provider Name	Home Nursing Care Providers	Home care Providers	Location
A Caring Experience Home Health Care, Inc	X		Providence
Access Healthcare Inc	X		East Providence
Alternative Care Medical Services	X		Providence
Assisted Daily Living, Inc	X		Warwick
Bayada Nurses Inc	X		Providence
Bayside Nursing, Llc	X		Warwick
Capitol Home Care Network, Inc.	X		Providence
Cathleen Naughton Associates	X		Providence
Child & Family Services Of Newport Cty		X	Middletown
Community Care Nurses Inc.	X		North Kingstown
Concord Health Services	X		Cranston
Consistent Care Corporation	X		Jamestown
Coventry Home Care Inc			Coventry
Cowesett Home Care Inc			Warwick
Dependable Healthcare Service, Llc	X		Hope Valley
Gleason Medical Services, Inc.	X		Cranston
H & T Medicals Inc	X		Cranston
Haigh Ventures Inc Dba Health Care Serv			Providence
Health Touch Inc	X		Wakefield
Healthcare Connections Nursing Services	X		East Providence
Home Care Advantage, Inc.	X		Cranston
Home Care Services Of Ri, Inc	X		Woonsocket
Homefront Health Care	X		Providence
Hope Nursing Home Care, Llc	X		Cranston
Ideal Home Care Services Inc		X	North Providence
Independence Health Services, LLC	X		Providence
Interim Health Care	X		Providence
Jewish Family Service			Providence
Kent County Visiting Nurse Association	X		Warwick
Lifetime Financial Mgt Inc Dba Lifetime		X	Pawtucket
Mas Medical Staffing Corp		X	North Providence
Maxim Healthcare Services, Inc	X		Providence
Morning Star Homecare Llc	X		Warwick
New England Home Infusion	X		Coventry
Newcare Llc	X		Middletown
Nursing Placement Inc.	X		Pawtucket
Ocean State Nursing Service Inc	X		Cumberland
Phenix Home Care & Nursing Service Inc		X	Cranston
Roger Williams Hospital Home Care	X		Providence
Saranna Inc	X		Pawtucket
Senior Helpers Of Rhode Island, Llc		X	Warwick
Simard Assoc,Inc Joyce			Westport
Specialty Personnel Services, Inc	X		Providence
St Jude Home Care Inc	X		Barrington

Provider Name	Home Nursing Care Providers	Home care Providers	Location
Summit Health Services Inc	X		Westerly
Tender Loving Care Health Care Services	X		Providence
The Memorial Hosp Of RI/Home Care Dept	X		Pawtucket
Vis. Nrse. Assoc. Of Se Mass. Inc.	X		Fall River
Visiting Nurse Serv Of Bristol & Newport	X		Portsmouth
Vital Care of Rhode Island, Inc	X		Lincoln
VNA Support Services Inc	X		Warwick
VNA, Inc.	X		Warwick
VNS Homecare	X		Narragansett
VNS of Greater Woonsocket	X		Lincoln
Visiting Angels		X	

Rhode Island licences Home Nursing Care Providers and Home Care Providers. Home Nursing Care Providers provide skilled nursing services and can also provide more general home care services (i.e; assistance with ADL's and IADL's). Home care providers do not provide skilled services but can provide assistance with ADL's and IADL's.

Assisted Living Facilities

Provider Name	Location
A Better Days Assisted Living	Pawtucket
Albion court	Providence
Ann's Rest Home	Providence
Ashberry Manor	North Providence
Assisted Living Manor	Pawtucket
Atria Aquidneck Place	Portsmouth
Atria Bay Spring Village	Barrington
Atria Lincoln Place	Lincoln
Autumn Villa	Cumberland
Blackstone Valley Assisted Living Centre	Central Falls
Blenheim Newport	Middletown
Briarcliffe Gardens	Johnston
Bridge at Cherry Hill	Johnston
Brightview Commons	Wakefield
Capitol Ridge of Providence	Providence
Carriage House at the Elms	Westerly
Charlesgate Senior Living	Providence
Colonial Manor	East Providence
Cortland Place	Greenville
Daniel Child House	Warren
Darlington Assisted Living Center	North Providence, Pawtucket(2 locations)
Donnella's Manor	Pawtucket
East Bay Manor	East Providence
Elms Assisted Living	Westerly
Emerald Bay Manor	Cumberland
Epoch of Blackstone Blvd	Providence
Epoch on the East Side	Providence
Ethan Place	Warwick
Evergreen Assisted Living	Woonsocket
Forest Farm Health Care Center Inc	Middletown
Franciscan Missions of Mary	North Providence
Franklin Court Assisted Living	Bristol
Golden Years	Westerly
Greenwich Bay Manor	East Greenwich
Greenwich Farms at Warwick	Warwick
Horizon Bay Coventry	Coventry
Jeanne Jugan Residence	Pawtucket
Manchester Manor Inc	Pawtucket
North Bay Manor	Smithfield
Northridge Manor	North Providence
Pocasset Bay Manor	Johnston
Saint Elizabeth Assisted Living	Providence
Sakonnet Bay Manor	Tiverton
Scandinavian Home	Cranston
South Bay Manor	Wakefield
Summer Villa, Inc	Coventry

Provider Name	Location
Sunrise House	Providence
Tamarisk Assisted Living	Warwick
The Seasons	East Greenwich
The Willows	Warren
Tockwotton Home	Providence
United Methodist Retirement Center DbA	East Providence
Victoria Court	Cranston
Village At Waterman Lake	Greenville
Warren Manor II	Providence
Weeden Manor	Pawtucket
West Bay Manor	Warwick
Winslow Gardens	Warren
Wyndemere Woods	Woonsocket

Adult Day Services

Provider Name	Location
Blackstone Health Inc	Pawtucket
Cornerstone Adult Services Inc	Warwick(2 Locations), Coventry, Bristol
Cranston Dept Of Senior Services/ Adult Day	Cranston
Dora C Howard Center Ltd	Greenville
Elmwood Adult Day Health Care	Providence
Forest Farm Health Care Centre	Middletown
Fruit Hill Day Services For Elderly	North Providence
Generations Adult Day Health Center	North Providence
Hope Alzheimer's Center	Cranston
Nancy Brayton Osborne	Tiverton
Senior Services Inc.	Woonsocket
To Life Center	Providence
The Willows Adult Day Care	Warren
Town Of South Kingstown Elderly Service	Wakefield
Westerly Adult Day Care Center	Westerly

APPENDIX D

LONG-TERM CARE ELIGIBILITY APPLICATION

Medical Assistance/Long Term Care Application

<http://www.dhs.ri.gov/FormsApplications/FormsApplications/MedicalAssistanceLongTermCareApplication/tabid/900/Default.aspx>

The following application packet is used for determining eligibility for Medical Assistance/ Long Term Care. For help with completing the application, see the numbers at the bottom.

- [DHS application Part 1](#) (DHS-1)
- [DHS application Part 2](#) (DHS-2)
- [Authorization for Disclosure/ Use of Health Information](#) (DHS-25M)
- [Authorization to Obtain or Release Confidential Information](#) (DHS-25)
- [Savings/Checking Account Request for Information](#) (DHS-91)
- [Certification of Citizenship/Alienage](#) (DHS-SAV-1)
- [Liens and Recovery Notice](#) (MA-89 LR) -signature is voluntary
- [Transportation Options](#) (MA-400 T)
- [Home and Community Based Waiver-Notification of Recipient Choice](#) (CP-12)
- [Race/Ethnicity Form](#) (RE-1) - completing this is voluntary
- [HIPAA Notice of Privacy Practices](#) (HIPAA-1)
- [Medical Assessment for DEA Home and Community Based Care](#) (HCC-1C)
- [Medical Evaluation of Applicant for Level of Care](#) (AP-72.1)

For help with the application, please call a DHS Long Term Care office, DEA Home and Community Care, one of the DEA Case Management Agencies or the Point.

[DHS Long Term Care Offices](#)

[DEA Case Management Agencies](#)

DEA Home and Community Care (401) 462-0570

The Point (401) 462-4444

APPENDIX E

COMPREHENSIVE ASSESSMENT TOOL

(Contains two parts: (1) Comprehensive Transition Assessment and (2) Transition Challenges and Risk Assessment)



Rhode Island Department of Human Services

Part 1: COMPREHENSIVE TRANSITION ASSESSMENT

REFERRAL

Assessment Date: _____ Referral Type: _____

NH Name: _____ HCBS ASL

NH Location: _____ NH Re-Assess

NH Address: _____ Preventive MFP

_____ Other: _____

NH D/C Planner: _____ Tel #: _____

CLIENT IDENTIFYING DATA

Medicare Ins Type: _____ Other Insurance: _____

Name: _____ DOB: _____ SSN: _____

Address: _____ Apt#: _____ Floor: _____

City/Town: _____ Zip: _____ Phone: _____

Primary Language: _____ Interpreter Needed: Yes No

Primary Contact Person: _____ Is this person a Legal Guardian/POA/DPOA? Yes No
(circle one)

Relationship: _____ Contact Phone: _____

Address: _____ City/Town _____ State _____ Zip _____

Marital status:

Married Divorced Separated

Never Married Widowed Unmarried Partner

Did Client Have Previous Involvement with DEA Protective Services? Yes No

If yes, DEA notification date: _____

Advanced directives _____

INFORMAL SUPPORTS (FAMILY, FRIENDS, ETC.)

Name	Relationship	Contact Information

PRE NH ADMISSION LIVING ARRANGEMENTS

Housing Status

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> State Institution | <input type="checkbox"/> Group Home | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Own Home | <input type="checkbox"/> Rents Home | <input type="checkbox"/> Subsidized Apt | |
| <input type="checkbox"/> Lives Alone | <input type="checkbox"/> Lives w/ Spouse | <input type="checkbox"/> Lives w/ Children | <input type="checkbox"/> Lives w/ Parents |

Pt Living Preference: _____

RN Clinical Recommendation: _____

POST NH ADMISSION LIVING ARRANGEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Home w/ Family | <input type="checkbox"/> Group Home |
| <input type="checkbox"/> Home Alone | <input type="checkbox"/> Needs Housing Assistance |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Other: _____ |

LTC ELIGIBILITY REQUIREMENTS

LTC Social Worker: _____ Office Location: _____ Ph: _____

Does the client have a co-share? \$ _____ MA Eligibility Status: _____

PREVIOUS HOME BASED SERVICES

Services Client Receives	Provider Name	# of hours/days per wk
<input type="checkbox"/> Homemaker		
<input type="checkbox"/> CNA		
<input type="checkbox"/> Skilled Services		
<input type="checkbox"/> MOW		
<input type="checkbox"/> Hospice Care		
<input type="checkbox"/> Mental Health Services		
<input type="checkbox"/> Senior Center		
<input type="checkbox"/> Adult Day Center		
<input type="checkbox"/> Med Reminding/Cueing		
<input type="checkbox"/> Transportation		
<input type="checkbox"/> DME		

Recommendations: _____

FUNCTIONAL ABILITY/ADL'S

Key

I-Independent

S-Supervision/ Minimal Assistance

AMD-Moderate Assistance / AMX-Maximum Assistance

T-Total Dependence

1. _____ Supports for eating _____ Supports for preparing meals Comments: _____
2. _____ Supports for toileting Comments: _____
3. _____ Supports for mobility (specify with or without manual aid) _____ Supports for transferring Comments: _____
4. _____ Supports for personal hygiene/grooming _____ Supports for dressing _____ Supports for bed bath _____ Supports for showering _____ Supports for special skin care Comments: _____
5. _____ Supports for light housekeeping (including laundry) _____ Supports for heavy housework Comments: _____
6. _____ Supports for transportation _____ Supports for shopping Comments: _____
7. _____ Supports for finances _____ Supports for telephone ability Comments: _____
8. _____ Identify the degree of support needed in an emergent situation _____ Identify the degree of support needed during the night

Comments: _____

Communication:

Is client able to speak and verbally express him/herself? Yes No

Comments: _____

Name devices the client uses to communicate/understand others: _____

BEHAVIORAL HEALTH

(Check all that apply)

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Agitated | <input type="checkbox"/> Disoriented | <input type="checkbox"/> Resistant to care |
| <input type="checkbox"/> Alert | <input type="checkbox"/> Disruptive @ times | <input type="checkbox"/> Verbally Abusive & threatening |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Pleasant & cooperative | <input type="checkbox"/> Other: _____ |

ETOH Use: _____ How often: _____ Meetings: _____

Mini Mental/BIMS Score: _____ Date _____

Comments: _____

Information provided by: _____

FALL RISK

Does the client have a history of falls? Yes No

Comments: _____

HEARING & VISION

Hearing impaired Assistive devices
MD _____

Comments: _____

Vision impaired Glasses or device
MD _____

Indicate client's current vision quality (w/ glasses if used regularly):

- 1) Adequate – sees fine print 2) Impaired – sees larger print

- 3) Mod Impaired – limited vision 4) Highly Impaired – sees only light/shadows

Comments:

DIET

Diet:

NPO: _____ Parental: _____

Special instructions/preparations:

Comments:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Able to chew | <input type="checkbox"/> Able to swallow | <input type="checkbox"/> Aspiration precautions |
| <input type="checkbox"/> Own teeth | <input type="checkbox"/> Dentures | <input type="checkbox"/> Partial plate |

Comments:

DENTAL

Name of dentist: _____ Date of last visit: _____

HEIGHT/WEIGHT

Weight: _____ Height: _____

Recent gain: Yes No Recent loss: Yes No

HEALTH CARE PROVIDERS / SPECIALISTS

Type (PCP/ Specialist/ Clinic)	Name/Practice	Phone	Address
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Behavioral Health Providers			
Dentist			
Other: _____			
Other: _____			

PCP appointment after discharge: Date _____ Time _____

OTHER APPOINTMENTS:

SLEEP

Is client satisfied w/ sleep quality? Yes No # of hours per night _____

Comments:

MEDICAL ISSUES

Diagnosis: _____

- | | | | | |
|---|-----------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> CHF | <input type="checkbox"/> GI issues | <input type="checkbox"/> MS | <input type="checkbox"/> Seizure d/o |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> CVA | <input type="checkbox"/> HTN | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Chemo/radiation | <input type="checkbox"/> Cardiac | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune disorder | <input type="checkbox"/> Renal |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Dialysis | | | |

Comments:

Surgical History

Dates

Smoking: Yes No

Quit: Yes No If yes, how long? _____

Cessation Classes: Yes No

MEDICATIONS

Description	Dose	Frequency	Route	Why taken

Method of preparation:

Who administers medications?

Allergies:

Reaction:

Pharmacy:

Relieved w/:

Outcome:

DIABETES

Glucometer: _____

Frequency: _____

B.S. range: _____ Hgb A1C: _____ Checked
every _____

Podiatrist:

Diabetic shoes: _____ Diabetic teaching:

LABS

Tests:

Location: _____

Frequency _____

IMMUNIZATIONS RECEIVED

Flu vaccine H1N1 Pneumovax Tetanus Other _____

Goals for Client:

1. _____

2. _____

3. _____

TRANSITION RECOMMENDATIONS

Referral Options

Planned NH Discharge Date: _____

Case Management referred to: DEA CAP agency MHRH Preventive LOC OCP
(for NHTP client only)
 Other: _____

Client referred to: DEA Core DHS Core DEA MHRH
 Preventive Personal Choice HAB PACE

Recommended Home Based Service

Services Client Receives	Provider Name	# hours/days per wk
<input type="checkbox"/> Homemaker		
<input type="checkbox"/> CNA		
<input type="checkbox"/> Skilled Services		
<input type="checkbox"/> MOW		
<input type="checkbox"/> Hospice Care		
<input type="checkbox"/> Mental Health Services		
<input type="checkbox"/> Senior Center		
<input type="checkbox"/> Adult Day Center		
<input type="checkbox"/> Med Reminding/Cueing		
<input type="checkbox"/> Transportation		
<input type="checkbox"/> DME		

Medically Necessary Equipment

1)	5)
2)	6)
3)	7)
4)	8)

Skilled Services Required

Treatment or Service	Frequency	Provider

Recommendations for Transition:



Rhode Department of Human Services

Part 2: Transition Challenges & Risk Assessment

- Physical health
 - o Current, new, or undisclosed physical health problem or illnessⁱ
 - o Medical testing issues or delaysⁱⁱ
 - o Inability to manage physical health or illness in communityⁱⁱⁱ
 - o Missing or waiting for physical health related documents or records
 - o Other physical health issues (describe) _____

- Mental health or mental illness
 - o Current, new, or undisclosed mental health problem or illness^{iv}
 - o Current or history of substance/alcohol abuse with risk of relapse^v
 - o Dementia or cognitive issues^{vi}
 - o Inability to manage mental health/illness in community^{vii}
 - o Other mental health/illness issues (describe) _____

- Financial or insurance benefits
 - o Lack of or insufficient financial resources^{viii}
 - o Consumer credit or unpaid bills^{ix}
 - o SSDI, SSI, SAGA, SSA, VA, or other cash benefits^x
 - o Other financial benefits or issues^{xi}
 - o Insurance issues^{xii}

ⁱ Incl. hospitalization due to physical health

ⁱⁱ Inc. waiting for neuro-psych examination

ⁱⁱⁱ Inc. taking medications correctly; following up with treatment or care; self-monitoring of blood sugar, etc.

^{iv} Incl. emotional issues such as depression or anxiety, or behavioral issues related to mental health. Incl. hospitalization due to mental health issues

^v Includes abuse of legal drugs such as abuse of prescription medications

^{vi} Incl. impaired judgment due to cognitive issues

^{vii} Inc. taking medications correctly; following up with treatment or care.

^{viii} Inc. lack of financial resources to pay security deposit, or for services or supports. Incl. Medicaid spend down; anticipated denial of Medicaid services once in community.

^{ix} Incl. lack of/poor credit; unpaid balance or money owed to utilities, etc.

^x Incl. denial, delay, loss, or lack of State or Federal financial benefits; rejection or delay in application for financial benefits; over or under payment of benefits

^{xi} Incl. related to individual's or spousal finances; missing documents/records; denial, loss of, or waiting for approval of other benefits, including benefits such as food stamps or energy assistance. Excludes cash benefits from SSDI, SSI, SSD.

- Other financial issues (describe) _____
- Consumer engagement, awareness, and skills
 - Disengagement or lack/loss of motivation^{xiii}
 - Lack of awareness or unrealistic expectations regarding disability or needed supports^{xiv}
 - Lack of independent living skills^{xv}
 - Language or communication skills^{xvi}
 - Other consumer related issues (describe) _____
- Services and supports
 - Lack of transportation^{xvii}
 - Lack of PCA, home health, or other paid support staff^{xviii}
 - Lack of mental health services or supports (in facility or in community)^{xix}
 - Lack of alcohol, substance abuse, or addiction services (in facility or in community)^{xx}
 - Lack of assistive technology or durable medical equipment (excluding home modifications)^{xxi}
 - Lack of any other services or supports^{xxii}
 - Other issues related to services or supports (describe) _____
 - Lack of informal supports (family/friends)
- Waiver program
 - Targeted waiver full
 - Ineligible for or denial of waiver services
 - Current waivers do not meet consumer needs^{xxiii}
 - Waiting for evaluation, application review, or response from waiver agency/contact
 - Other waiver program issues (describe) _____
 - Client declines
- Housing

^{xii} Incl. issues with prescription insurance coverage, Medicare Part D, Medicaid, SAGA medical insurance, etc.

^{xiii} Incl. lack of follow through on responsibilities; decision to remain in facility and withdraw from program

^{xiv} Incl. resistance to or inflexibility regarding need or options for support

^{xv} Incl. if self-directing, consumer cannot manage PCA's or other support staff

^{xvi} Incl. language differences, no interpreter (incl. sign language interpreter), lack of communication device, etc.

^{xvii} Incl. insufficient, denial, wait for, or loss of transportation. Includes transportation to receive treatment, see apartments, get documents necessary to transition, or live in community.

^{xviii} Incl. insufficient, denial, wait for, difficulty obtaining, or loss of paid support staff

^{xix} Incl. insufficient, denial, wait for, or loss of mental health services or supports, either in the facility or in the community.

^{xx} Incl. insufficient, denial, wait for, or loss of alcohol, substance abuse, or addiction services or supports, either in the facility or in the community.

^{xxi} Incl. insufficient, denial, wait for, or loss of, or need for training for AT or DME; excludes home modifications or affordability issues

^{xxii} Incl. insufficient, denial of, wait for, or loss of any other types of services or supports (excludes PCA/direct support staff; mental health services, AT/DME, or home modifications)

^{xxiii} Incl. if no existing waiver for level of care, such as no 24 hour care waiver

- Lack of or insufficient housing^{xxiv}
 - Ineligible for or waiting for approval from RAP or other housing programs
 - Housing modification issues^{xxv}
 - Delays related to housing authority, agency, or housing coordinator
 - Delays related to lease, landlord, apartment manager, etc.
 - Other housing related issues (describe) _____
- Legal or criminal
- Consumer criminal history^{xxvi}
 - Probate court issues^{xxvii}
 - Missing or waiting for identity, birth certificate, or other related records
 - Legal representative issues^{xxviii}
 - Other court or legal issues (describe) _____
- Facility related
- Facility staff or administration issues^{xxix}
 - Waiting for, loss of, or absence of discharge planning
 - Evaluation of consumer by facility issues^{xxx}
 - Other facility related issues (describe) _____
- Other involved individuals
- Issues with spouse/partner, family, or friends^{xxxi}
 - Physical health provider/doctor opposed, unsupportive, or unresponsive
 - Mental health provider/doctor opposed, unsupportive, or unresponsive
 - Other provider or state agency opposed, unsupportive, or unresponsive^{xxxii}
 - Other issues related to involved individuals (describe) _____
- MFP Office or Transition coordinator
- Transition plan not approved
 - Waiting for response, approval, etc. from MFP Office
 - Lack of time for transition coordinator to follow up
 - Other transition coordinator issues (describe) _____
 - Other MFP Office issues (describe) _____
- Other topical area creating challenge^{xxxiii}

^{xxiv} Incl. denial of, wait for, or loss of accessible or committed housing; consumer dissatisfaction with or inflexibility available residence or living arrangement

^{xxv} Incl. modifications not completed or not yet authorized

^{xxvi} Incl. current criminal issues, such as incarceration

^{xxvii} Incl. probate judge issues

^{xxviii} Incl. lack of legal representative if applicable; legal representative opposed, unsupportive, unresponsive; Incl. all legal representatives, such as conservator, guardian, etc.

^{xxix} Incl. opposed, unsupportive, unresponsive, etc.

^{xxx} Incl. delay in, wait for, or lack of any type of evaluation for which the facility/facility staff is responsible

^{xxxi} Incl. opposed, unsupportive, unresponsive, etc. Includes financial exploitation.

^{xxxii} Incl. opposed, unsupportive, unresponsive, or absence of provider/state agency or their staff; Incl. care manager or care planner from provider or state agency (excludes staff from current facility);

- Describe: _____
- Previous DEA Protective Services issues:
Date: _____
Describe:

FOOTNOTES:

NOTE: These will be used to clarify and further describe subcategories.

^{xxiii} Multiple additional areas can be created

APPENDIX F

HOUSING ASSESSMENT TOOL

(Contains two parts; (1) Qualified Resident Assessment, and (2) Home Safety Checklist)

Part 1: QUALIFIED RESIDENCE ASSESSMENT

Living Arrangement	Yes	No	Comments
HOME			
Is the home owned or leased by the individual or the individual's family member?			
If leased, the lease must be the participant or family member.			
If participant share the home they own or lease, they either may sublet or rent with a granting the other person exclusion possession to the space or enter into a co-ownership or co-leasing arrangement.			
In either case, both parties must retain independent and equal rights to enforcement of the lease and/or ownership responsibilities.			
APARTMENT			
Does the apartment have an individual lease with lockable access and egress to the unit?			
Does the apartment have living, sleeping, bathing and cooking areas over which the individual or the individual's family has domain and control?			
The lease must be in participant's name or a family representative.			
The apartment must comport with federal fair housing requirements.			
The lease should not include: (1) rules and/or regulation from a service agency as conditions of tenancy or include a requirement to receive services from a specified company, (2) required notification of absence periods, (3) include provision for being admitted , discharged or transferred out of or into a facility, and (4) reserve the right to assign apartments and change apartment assignments			
COMMUNITY BASED RESIDENTIAL SETTING			
No more than 4 unrelated individual reside there.			
Is not part of a larger congregate care setting (Campus) separated from typical community dwelling.			
The resident must be owned and operated by a person or organization other than the individual.			
Care givers such as personal attendants are not counted in the for maximum unrelated individuals.			
ASSISTED LIVING			
Occupancy is governed by a lease.			
A contract or agreement is consistent with the provision of a standard lease.			

Living Arrangement	Yes	No	Comments
Unit has lockable access and egress.			
Occupancy of the unit does not require that services must be provided as a condition of tenancy or from a specific company.			
The facility may not require notifications of absences.			
Aging in place provisions are required for qualified residences,			
Lease may not reserve the right to assign apartments or change apartment assignments.			

Part 2: HOME SAFETY CHECKLIST

Name: _____

✓ Living Room – Family Room

Check the box that applies:

Y N N/A

- | | Y | N | N/A |
|--|--------------------------|--------------------------|--------------------------|
| 1. Can you turn on a light without having to walk into a dark room? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are lamp, extension or phone cords out of the flow of foot traffic in this room? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are passageways in this room free from objects and clutter (papers, furniture)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are curtains and furniture at least 12 inches from baseboard or portable heaters? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do your carpets lie flat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do your small rugs and runners stay put (don't slide or roll up) when you push them with your foot? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

✓ Kitchen

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 7. Are your stove controls easy to see and use? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you keep loose fitting clothing, towels, and curtains that may catch fire, away from the burners and oven? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is there a working fire extinguisher available? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are all appliances in working order? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are counter tops free from clutter? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Can you reach regularly used items without climbing to reach them? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have a step stool that is sturdy and in good repair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

✓ Bedrooms

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 14. Do you have a working smoke detector on the ceiling outside your bedroom door? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Can you turn on a light without having to walk into a dark room? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. If available, are pull cords visible and accessible? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have a lamp or light switch within easy reach of your bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Is there enough room to maneuver around the bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Are there safety rails on the bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. If there is a commode, is it placed close to the bed and against a wall? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Is a phone within easy reach of your bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Is a light left on at night between your bed and the toilet? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Are the curtains and furniture at least 12 inches from your baseboard or portable heater? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

✓ Bathroom

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 24. Does your shower or tub have a non-skid surface: mat, decals, or abrasive strips? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. If available, are pull cords visible and accessible? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Is there a shower or transfer bench in place? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Does the tub/shower have a sturdy grab-bar (not a towel rack)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Is your hot water temperature 120° or lower? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Does your floor have a non-slip surface or does the rug have a non-skid backing? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Are you able to get off and on the toilet easily? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

✓ Stairways

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 31. Is there a light switch at both the top and bottom of inside stairs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. With the light on, can you clearly see the outline of each step as you go down the stairs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do all of your stairways have sturdy handrails on both sides? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do the handrails run the full length of the stairs, slightly beyond the stairs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Are all steps in good repair (not loose, broken, missing or worn in places)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

36. Are stair coverings (rugs, treads) in good repair, without holes and not loose, torn or worn?

✓ Hallways and Passageways

37. Do all small rugs or runners stay put (don't slide or roll up) when you push them with your foot?

38. Do your carpets lie flat?

39. Are all lamp, extension and/or phone cords out of the flow of foot traffic?

✓ Front and Back Entrances

40. Do all entrances to your home have outdoor lights?

41. Are the locks on the doors in proper working condition?

42. Are walkways to your entry free from cracks and holes?

✓ Throughout Your House

43. Do you have an emergency exit plan in case of fire?

44. Are the floors and living areas free from clutter?

45. Are there any chairs on wheels that could pose as a hazard?

46. Is there a working flashlight in case of a power outage?

47. Are the doorways and walk spaces wide enough for a wheelchair and/or walker?

48. Do you have emergency phone numbers listed by your phone?

49. Are there telephones located in at least 2 rooms?

50. Are there other hazards or unsafe areas in your home not mentioned in this checklist that you are concerned about? If so, what?

Making Your Home Safer

What home safety changes do you want to make?

1. _____
2. _____
3. _____

Recommendations for improved safety: _____

Signature of Transition Coordinator/Peer Mentor:

Date:

Signature of Client:

Date:

APPENDIX G

CARE PLAN

(Contains three parts: (1) Service Plan, (2) Risk Mitigation Plan, and (3) Emergency Back-Up Plan)

RHODE to HOME

Part 1: SERVICE PLAN

Name: _____ Case#: _____ Date: _____

Initial Assessment Reassessment Change

DHS Core Preventative DEA Core Personal Choice HAB BHDDH

I. SERVICES

1. Goal:		7. Goal:	
Service:	Personal Care	Service:	Adult Day Care
Provider:		Provider:	
Provider:		Frequency:	
Frequency:		Duration:	
Duration:			
2. Goal:		8. Goal:	
Service:	House Hold Tasks	Service:	Case Management
Provider:		Provider:	
Provider:		Frequency:	
Frequency:		Duration:	
Duration:			
3. Goal:		9. Goal:	
Service:	Meals on Wheels	Service:	Respite Service
Provider:		Provider:	
Frequency:		Frequency:	
4. Goal:		10. Goal:	
Service:	Emergency Response System	Service:	Senior Companion
Provider:		Provider:	
Frequency:		Frequency:	
Duration:		Duration:	
5. Goal:		11 Goal:.	
Service:	Minor Assistive Devices	Service:	Transportation
Provider:		Provider:	
Device:		Provider:	
Device:		Frequency:	
6. Goal:		12. Goal:	
Service:	Medication Management	Service:	Other:
Provider:		Provider:	
Frequency:		Frequency:	
Duration:		Duration:	

11. PRIMARY CARE: _____

III. RESIDENTIAL PLAN AND HOME MODIFICATIONS: _____

IV. HUMAN SERVICES; _____

V. FORMAL AND INFORMAL SUPPORTS: _____

VI. RECREATIONAL AND CULTURAL: _____

VII.SPECIALNEEDS: _____

VII. RESPONSIBILITY FOR REFERRAL AND LINKAGES: _____

VIII. CARE TEAM MEMBERS: _____

RHODE TO HOME

Part 2: RISK AND MITIGATION PLAN

Identify Risks indicated on Comprehensive Assessment and Housing Safety Checklist

1. Risk:	
Intervention:	
2. Risk:	
Intervention:	
3. Risk:	
Intervention:	

4. Risk:	
Intervention:	
5. Risk:	
Intervention:	
6. Risk:	
Intervention:	



Part 3: EMERGENCY BACK-UP PLAN

Consumer Name		County
Address		Telephone No.
City	State	Zip Code
Physician Name		Physician Fax No.
List of Special Communication Needs		

LIST OF SERVICES NEED FOR HEALTH, SAFETY & WELL-BEING

LEVEL 1: PARTICIPANTS OWN BACK-UP (E.G. Family, Guardian, Friends/Neighbors etc.):		
LEVEL 2: AGENCY/PROVIDER BACKUP		
Contact	Name	Telephone No.
Home Health Agency		
Nurse Case Manager		
Social Worker		
Adult Day		
Transportation		
Other:		
Other:		
LEVEL 3: Rhode to Home Contracted Agency (TBD):		

OTHER LEVEL: Transition Coordinator/Peer Mentor

EMERGENCY NUMBERS

Type	Telephone No.
Police/Fire Rescue	911
(Name and Number of Contracted Agency TBD)	
DEA Protective Services (for reports of abuse & neglect)	401-462-0555
Example: DEA After Hours Program for Elders in Crisis	401-462-3000
Example: Alliance for Better Long Term Care (for complaints about Assisted Living, NH's & Home Health Agencies)	401-785-3340

TRANSPORTATION FOR PARTICIPANT

Family, Friends & Neighbors, Senior Citizen Taxi, Taxi	
Name of Agency	Telephone No.

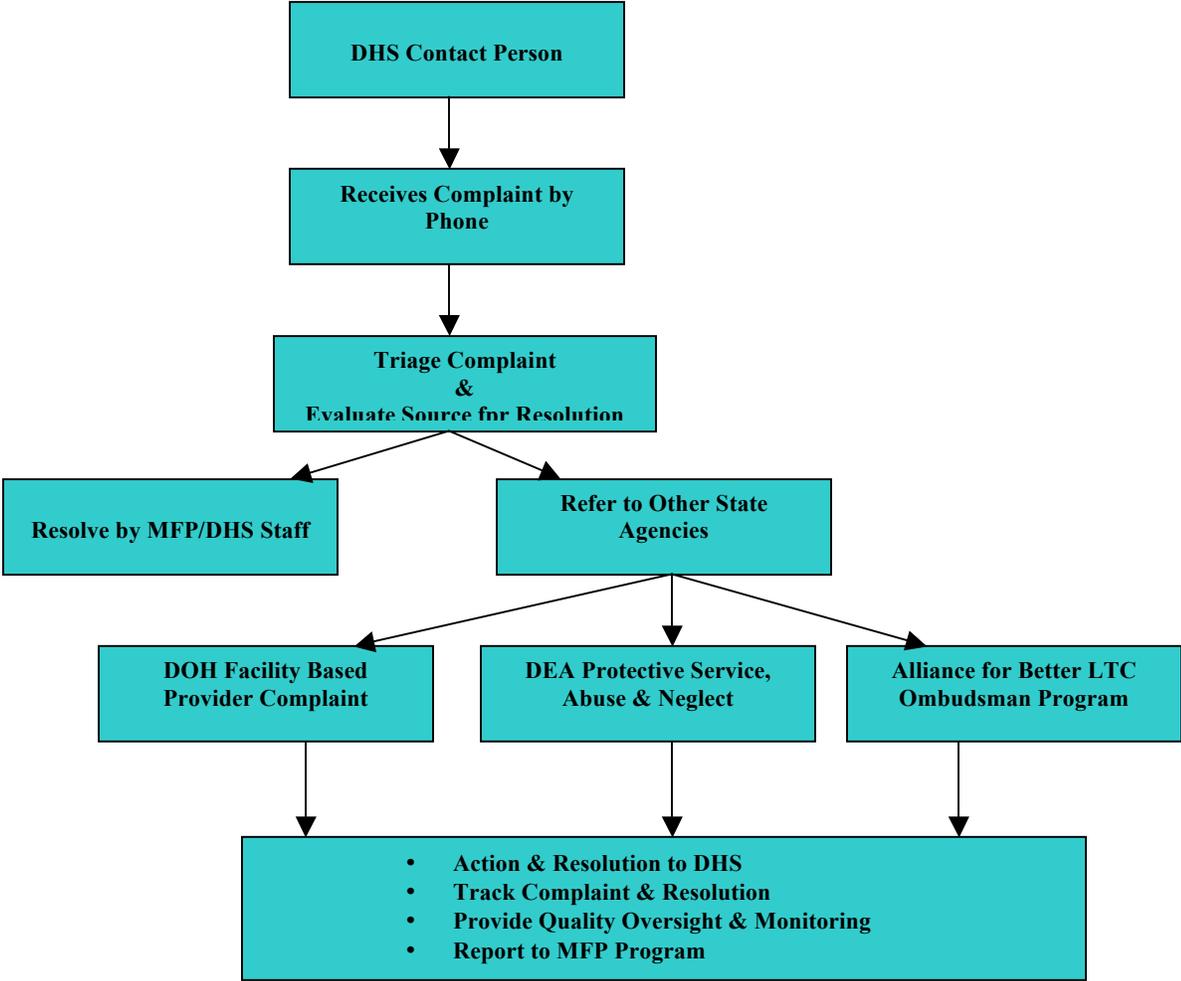
HOME MEDICAL EQUIPMENT REPAIR OPTIONS

Consumer's Home Medical Equipment	Agency Leased/Purchased From	Agency Telephone No.

APPENDIX H

DHS CRITICAL INCIDENTENCE FLOW CHART

CRITICAL INCIDENTS TRIAGE PROCESS



APPENDIX I
INFORMED CONSENT

DEPARTMENT OF HUMAN SERVICES
STATE OF RHODE ISLAND

**INFORMED CONSENT FOR PARTICIPATION IN THE *RHODE TO HOME*
MONEY FOLLOWS THE PERSON DEMONSTRATION PROJECT**

I have been informed that I can join the RHODE TO HOME program. This is a program that helps people like me live safely and securely in the community.

The RHODE TO HOME program will help me move from where I live now into a home, apartment or group housing. The RHODE TO HOME program will help me get settled. The program will arrange for services that I need and am eligible to receive.

I will be part of the team that creates a plan that describes the kinds of help I need. I will be part of the team that makes sure the plan is working.

The program lasts for 365 days. At the end of the year, I may receive different services from Rhode Island Long Term Care. I can get these services as long as I meet the eligibility rules for Long Term Care.

The RHODE TO HOME program is the state's Money Follows the Person Demonstration Project. It is funded by the federal Centers for Medicare and Medicaid Services (CMS).

CMS, the federal agency in charge of the program, wants to learn how this program is helping people. Information about my participation in the RHODE TO HOME program will be given to CMS and to Mathematica Policy Research. A researcher may contact me during the year. I will be asked questions about my experience in the RHODE TO HOME program in person, on the telephone or in writing.

I was given a description of the research plan. The description included the goals of the research, the kinds of data, how my privacy will be protected, what CMS hopes to learn, and who to call if I have questions.

PRIVACY

All the information about me is confidential and will be used only to learn about the RHODE TO HOME program.

LEAVING THE RHODE TO HOME PROGRAM

I can leave the RHODE TO HOME program at any time by completing a withdrawal form. Leaving the program will not affect my eligibility for other Medicaid and home and community based services. I can get the withdrawal form from my Transition Coordinator or Peer Mentor or download a copy at www.ri.dhs.gov.

EMERGENCY CONTACT INFORMATION

I have written information about what I should do if I have a non-medical emergency. I can call my transition coordinator or peer mentor if my home care worker does not show up or my equipment breaks.

COMPLAINTS

If I have any complaints or concerns about my participation in the RHODE TO HOME program I can contact the DHS Project Director, [name, title, phone, street, city, email]

I have been informed that I may file a grievance or appeal of a decision. The care manager or service coordinator has explained how to file a grievance or appeal. I have a written summary of how to start the process.

CONSENT

I will be given a signed copy of this consent form to keep. If I have questions about the operational and benefit aspects of the MFP Demo that cannot be answered by the care manager or service coordinator, I can call [project director name and contact info]

SIGNATURE – Participant	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number ()
SIGNATURE – Legal Guardian (if applicable)	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number ()
CARE MANAGER ACKNOWLEDGEMENT I have read the informed consent materials to the applicant, and I believe that he/she (or the guardian, if signed) understands the materials.	
SIGNATURE – Care Manager / Service Coordinator	Date Signed
Name – Agency	Telephone Number ()

OPTION TO FORMALLY DECLINE PARTICIPATION	
I was offered the opportunity to participate in the MFP demo and have chosen to decline . I understand that this will not affect my eligibility for Medicaid or home and community-based services.	
SIGNATURE – Participant	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number () -

SIGNATURE – Legal Guardian (if applicable)	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number () -

APPENDIX I

SELF-DIRECTED TEMPLATE

Sub-Appendix I: Self-Direction

Components of Self-Direction from the 1915(c), 3.5 Waiver Application

Participant direction of waiver services means that the participant has the authority to exercise decision making authority over some or all of her/his services and accepts the responsibility for taking a direct role in managing them. Participant direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the participant-centered service plan. Participant direction promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered. For example, the participant may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports. When a service is provider-managed, a provider selected by the participant carries out these responsibilities.

Incorporating participant direction involves several interrelated dimensions. The following is an overview of the main dimensions of participant direction:

Participant Choice

Self-direction may permit participants to direct some or all of their services or opt instead to receive provider-managed services exclusively. Decision making authority, references to the participant mean: (a) the participant acting independently on her/his own; (b) the parent(s) of a minor child who is a waiver participant acting on behalf of the child; (c) a legal representative when the representative has the authority to make pertinent decisions on behalf of the participant; and, (d) when permitted by the state, a non-legal representative who has been freely chosen by the participant to make decisions on the participant's behalf.

Participant Direction Opportunities

There are two basic participant direction opportunities. These opportunities may be and often are used in combination and are not mutually exclusive. The opportunities are:

- **Participant Employer Authority.** Under the Employer Authority, the participant is supported to recruit, hire, supervise and direct the workers who furnish supports. The participant functions as the common law employer or the co-employer of these workers. When the Employer Authority is utilized, the participant rather than a provider agency carries out employer responsibilities for workers.
- **Participant Budget Authority.** Under the Budget Authority, the participant has the authority and accepts the responsibility to manage a participant-directed budget. Depending on the dimensions of the budget authority it permits the participant to make decisions about the acquisition of goods and services that are authorized in the service plan and to manage the dollars included in a participant-directed budget.

- **Supports for Participant Direction**

Two types of supports may be made *available* to facilitate participant direction. These supports may be furnished as a service under a Medicaid payment authority (principally as a Medicaid administrative activity).

- **Information and Assistance in Support of Participant Direction:** These supports are made available to participants to help them manage their waiver services. For example, assistance might be provided to help the participant locate workers who furnish direct supports or in crafting the service plan. The type and extent of the supports that must be available to participants depends on the nature of the participant direction opportunities provided.
- **Financial Management Services:** These services are furnished for two purposes: (a) to address Federal, state and local employment tax, labor and workers' compensation insurance rules and other requirements that apply when the participant functions as the employer of workers and (b) to make financial transactions on behalf of the participant when the participant has budget authority. There are two types of FMS services that may be employed to support participants who exercise the Employer Authority: (1) Fiscal/Employer Agent (Government or Vendor) where the entity is the agent to the common law employer who is either the participant or his or her representative or (2) Agency with Choice, where the participant and the agency function as co-employers of the participant's worker(s). While their main purpose is to facilitate participant direction of services, these supports also provide important protections and safeguards for participants who direct their own waiver services.

CMS Funding Sources

Self-Direction can be funded by a variety of mechanisms by CMS, including funding authorities such as section 1915(c) home and community-based services waiver programs and section 1915(b) managed care, waiver programs. The Deficit Reduction Act of 2005 added new options for self-directed services States that wish to continue self-direction beyond the grant period for individuals will need to consider which authority to use. These options are summarized in the table below. (Note: section 1915(c) waiver authority policy on self-direction was developed in conjunction with the 1915(c) waiver application and is comprehensively documented in the Instructions, Technical Guide and Review Criteria for the application found at the following website:

http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers

Reading the provisions in the 1915(c) waiver template are a good starting point for all self-direction initiatives. Various restrictions are present under this and other authorities and CMS should be consulted if you have questions about the authority that is best suited to your circumstances. The following table summarizes significant issues under the various authorities.

	Component		Funding Authority		
	1915(c)	1915(b)	Benchmarks (DRA 6044)	Section 1915(i) (DRA 6086)	Section 1915(j) (DRA 6087)
Services	See Appendix C of the waiver instructions for service options	Includes ability to use savings from managed care programs to fund alternative services	Includes ability to create enhanced service packages	Includes HCBS allowed under 1915(c)	Can self-direct either State plan PCS or HCBS under 1915(c)
State -wideness	May waive	May waive	May waive	Cannot	States may disregard
Comparability	States may waive	States may waive	States may waive	Cannot	States may disregard
Populations	Populations who meet a Medicaid institutional level of care	Includes all populations	Includes all populations	Includes all populations	Includes all populations
Authority to Manage Cash	Cannot manage cash	Cannot manage cash	May not manage cash	May not manage cash	Allowed, at State's option
Limit #s of people	May limit numbers	May limit numbers	May limit numbers	May not limit numbers	May limit numbers
Institutional Eligibility Rules	May waive	May waive	May waive	May waive	Does not change person's eligibility for either State plan PCS or HCBS waiver services
[1902(a)(10)(c)(i)(III)] Provider Agreements [1902(a)(27)]	May not waive	May not waive	May not waive	May not waive	May not waive

Self-Direction Submittal Form

I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development.** Specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case Manager. <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input checked="" type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>): Participant Service Advisor working for agency meeting Medicaid standards

b. **Service Plan Development Safeguards.** *Select one:*

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Under the Personal Choice program the Service Advisor team (advisor, RN and mobility specialist) focuses on empowering participants (and anyone he/she chooses to include) to define and direct their own personal assistance needs and services; the team guides and supports, rather than directs and manages, the participant through the service planning and delivery process. The Service Advisor counsels, facilitates and assists in development of an Individual Service and Spending Plan which includes both paid and unpaid services and supports designed to allow the participant to live independently in the home and community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the Individual Service and Spending Plan are temporarily unavailable. The Service Advisor also provides the information and skills trainings needed to manage one's own care in the areas of rights and responsibilities of both the Participant and Worker; recruiting and hiring workers; developing schedules and outlining duties; supervising and evaluating workers; how to access the services and goods identified in the Individual Service and Spending Plan; managing the monthly budget, assists with completion of necessary paperwork and, helps the Participant ensure that his/her rights and safety are protected. The Service Advisor also monitors the provision of care and expenditures from the Individual

Service Plan and maintains contact with the participant to assure that the needed care is provided. The Service Advisor is also responsible for identifying the need for a representative and assuring that the representative meets the qualifying criteria. The team is available to all participants as needed for skills trainings, assessments, and assistance in accessing any needed support or service.

- d. Service Plan Development Process** In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Service Advisor meets with and assists the participant (and anyone else the participant wishes to be involved) in writing the plan by advising on potential distribution of assistant hours, and other needs and goals identified through the team assessment process.

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Each participant is screened for capacity to direct care and required to identify a representative to direct care if indicated. Each participant is required to identify his/her back-up plan at the time of plan development. This can include other individual assistants or agency services.

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

Each participant signs that they received and selected from a list of qualified providers for service advisement and fiscal agent services at the time of enrollment, and are informed by the Service Advisor that they may choose any provider they wish for any of their services under Medicaid.

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

Medicaid agency approves all service plans/budgets for the Personal Choice program prior to implementation via the web-based Consumer Direction Module.

h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following (*check each that applies*):

<input checked="" type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

II. Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Participant Service Advisor – quarterly in-person visits and monthly telephone contact in the first year, then semi-annual in-person and quarterly phone contact thereafter or more when requested or indicated by concern. Additionally, the RN and Mobility Specialist assess for needs at least annually. The entire team is available to the participant upon request and/or Advisor identification of a potential health/safety concern.

- b. **Monitoring Safeguards.** *Select one:*

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>

III. Overview of Self-Direction

- a. **Description of Self-Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

The Personal Choice program implemented a Cash and Counseling program in the state of Rhode Island. This is a model of participant directed home and community based long term care which will afford participants the opportunity to direct their individual waiver services under the PersonalChoice program. This program will be offered to MFP participants in addition to other models of HCBS other waivers serving individuals meeting either the High or Highest Level of Care. The following is a brief description of the PersonalChoice program:

- (a) Every participant (or their representative) enrolled is able to direct his or her direct services under PersonalChoice. These services are: Personal Care Assistants and Participant Directed Goods and Services. Each participant will be provided with an individualized budget amount developed utilizing a common methodology. The individualized budget is based upon the participant's need for assistance in performance of ADLs and IADLs, as determined by a functional assessment completed by the Advisement Team during the initial assessment or yearly re-assessment. Participants then receive a monthly budget allotment to develop an Individual Service and Spending Plan detailing how they will purchase Personal Care Assistant services and Participant Directed Goods and Services.
- (b) Participants may select PersonalChoice at three points: at initial theMFP entry assessment, at the re-evaluation assessment, or at any time.
- (c) PersonalChoice uses DHS/IRS certified vendor fiscal/employer agents; and service advisement agencies both of which are required to meet state established certification standards to provide supports to participants. The participant (or their representative) will function as the common law employer (employer of record) of workers who will provide services. The fiscal/employer agents will provide financial management services for the participant. The counseling/service advisement agencies provides services to the participant designed to assist them in arranging for, directing, and managing self-directed services. All participants are required to utilize financial management and service advisement services, but can select from any qualified provider. Service advisement services include orientation/education/training in participant direction, assistance in developing Individual Service Plan and ongoing monitoring for participant health and safety and satisfaction. The Fiscal Agency of the participant's choice conducts criminal background and abuse registry checks on all new employees hired by the participant prior to being eligible for reimbursement under the waiver.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the demonstration. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant’s representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant’s representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	Both Authorities. The demonstration provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
<input checked="" type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
<input checked="" type="checkbox"/>	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual’s family has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

<input type="radio"/>	The demonstration is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input checked="" type="radio"/>	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i> Participant Direction opportunities will be limited to the following services: <ul style="list-style-type: none"> ❖ Personal Care Assistance Services ❖ Participant Directed Goods and Services ❖ Respite

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant’s representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information Furnished to Participants:

- (a) The following information will be provided to participants
- Principles and benefits of participant direction
 - Participants rights, roles and responsibilities
 - PersonalChoice selection form
 - Description of other Waiver programs
 - Fiscal/Employer agent contact information
 - Counseling/Service Advising agency contact information
 - Grievance and Appeal process and forms
 - Roles and responsibilities of the Fiscal/Employer Agent and the Counseling/Service Advising Agency.
 - Participant-directed planning
- (b) Trained Advisors from the Service Advisement agency provide the information to participants.

This information is provided to participants during their initial assessment for the PersonalChoice program.

- f. Participant Direction by a Representative.** Specify the State’s policy concerning the direction of demonstration services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of demonstration services by a representative.	
<input checked="" type="radio"/>	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: (<i>check each that applies</i>):	
	<input checked="" type="checkbox"/>	Demonstration services may be directed by a legal representative of the participant.
	<input checked="" type="checkbox"/>	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		The representative cannot be paid from the participant budget in order to avoid decision-making that might not be in the client’s best interest, must pass a screen indicating ability to perform function in best interest of participant and must pass a criminal background check.

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities), available for each demonstration service. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Personal Care Assistance Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Participant Directed Goods and Services	X	X
Respite	X	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one:*

<input checked="" type="checkbox"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="checkbox"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. *Select one:*

<input checked="" type="checkbox"/>	FMS are covered as a Demonstration service	Fill out i. through iv. below:
<input type="checkbox"/>	FMS are provided as an administrative activity. Fill out i. through iv. below:	
	i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: Fiscal/Employment Agency that meets Medicaid certification standards (includes IRS qualifications). Each participant is given a list of certified providers and chooses one provider. All participants are required to enroll with a Fiscal Agency.
		ii. Payment for FMS. Specify how FMS entities are compensated for the activities that they perform: FMS entities are compensated on a monthly basis (flat fee)
	iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i> <i>Supports furnished when the participant is the employer of direct support workers:</i>
		<input checked="" type="checkbox"/> Assist participant in verifying support worker citizenship status
		<input checked="" type="checkbox"/> Collect and process timesheets of support workers
		<input checked="" type="checkbox"/> Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		<input checked="" type="checkbox"/> Other <i>(specify):</i> Conducts Criminal Background checks on all direct service workers and participant representatives.
		<i>Supports furnished when the participant exercises budget authority:</i>
		<input checked="" type="checkbox"/> Maintain a separate account for each participant's self-directed budget

	<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance—of participant funds	
	<input checked="" type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan	
	<input checked="" type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the self-directed budget	
	<input type="checkbox"/>	Other services and supports (<i>specify</i>):	
	<i>Additional functions/activities:</i>		
	<input type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency	
	<input type="checkbox"/>	Other (<i>specify</i>):	
	iv.	Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	
		On an Annual basis RIDHS performs random sample reviews of client files and billing records and they are compared to the clients approved service plan.	

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:</i>
<input checked="" type="checkbox"/>	Demonstration Service Coverage. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled: Supports for Consumer Direction
<input type="checkbox"/>	Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i>

k. Independent Advocacy (*select one*).

<input checked="" type="checkbox"/>	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i> All RI Medicaid clients have advocacy available through the RI Disability Law Center (P&A agency)
<input type="checkbox"/>	No. Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Service Advisor works with participant to transfer to alternate waiver and monitors health and safety until the new service is fully implemented.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants who demonstrate the inability to self-direct waiver services whether due to misuse of funds, consistent non-adherence to program rules or an ongoing health and safety risk, will be required to select a representative to assist them with the responsibilities of self-direction. If a participant refuses to select a representative, or if participant loses a representative (if already required for program participation) and cannot locate a replacement, they will be required to transfer to another waiver program that has traditional agency oversight. Service advisors will assist the participant in the transition to the traditional agency to ensure continuity of care.

n. Goals for Participant Direction. In the following table, provide the State’s goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	Number of Participants	Number of Participants
Year 1		
Year 2		
Year 3		
Year 4		
Year 5		

IV. Participant Employer

a. **Participant – Employer Authority** (Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)

1. **Participant Employer Status.** Specify the participant’s employer status under the demonstration. Check each that applies:

X	<p>Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</p>
	RI utilizes this model for the provision of Respite Services under an “agency with choice” model.
X	<p>Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.</p>

2. **Participant Decision Making Authority.** The participant (or the participant’s representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

X	Recruit staff
X	Refer staff to agency for hiring (co-employer)
X	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
<input type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
X	Specify additional staff qualifications based on participant needs and preferences
X	Determine staff duties consistent with the service specifications
X	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	Discharge staff (common law employer)
X	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (specify):

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b. Participant – Budget Authority (Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)

1. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

<input checked="" type="checkbox"/>	Reallocate funds among services included in the budget
<input checked="" type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input checked="" type="checkbox"/>	Substitute service providers
<input checked="" type="checkbox"/>	Schedule the provision of services
<input checked="" type="checkbox"/>	Specify additional service provider qualifications
<input checked="" type="checkbox"/>	Specify how services are provided,
<input checked="" type="checkbox"/>	Identify service providers and refer for provider enrollment
<input checked="" type="checkbox"/>	Authorize payment for demonstration goods and services
<input checked="" type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (specify):

2. **Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

A detailed assessment of ADL and IADL needs is submitted to the Medicaid office via the web-based CDM as part of the assessment. Average task time with additional time allocated for certain functional characteristics that can affect ADL task time (such as spasticity) is multiplied by a factor to determine the budget. The factor is based on 85% of agency CNA reimbursement because it is a rate that is regularly adjusted for COLA changes, and is the average amount previously spent on equivalent services and supports in the former consumer directed waiver. This budget is used for personal care assistants including their personnel costs under IRS and State statute and participant directed goods and services once the service advisement and fiscal intermediary monthly payments have been deducted. The cost to obtain Criminal Background Checks is part of the monthly Fiscal Agent reimbursement amount.

3. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Letter to participant with due process notice

4. **Participant Exercise of Budget Flexibility. Select one:**

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input checked="" type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

5. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The budget is allocated on a monthly basis. ISSP approved Goods and Services exceeding the monthly budget amount after needed personal care services are deducted must be budgeted over more than one month and purchased once money is accumulated in the budget. The Fiscal agent reports monthly to Participant and Advisor, and quarterly to state on the budget disbursements and balances. The budget is an electronic and paper document. No actual cash disbursements are given until the service has been rendered. The service advisor work with the participant whenever the level of personal care declines below 80% of authorization. Resolution may include assisting in locating a new worker or reassessment of needs.

Appendix K:
DCYF MFP Phase II

Implementation of MFP Demonstration for Populations Served by Rhode Island Department of Children, Youth and Families

This Appendix represents our preliminary effort to implement the Phase II portion of the MFP Demonstration for the Department of Children, Youth and Families (DCYF) population. Certain areas of this exhibit will slightly differ from the Phase I MFP Demonstration due to the nature of the Phase II DCYF target population being children and youth in psychiatric hospitals and in-state and out-of-state IMDs.

The DCYF has statutory responsibility for child welfare, juvenile justice, and children's behavioral health services in Rhode Island. In State Fiscal Year (SFY) 2010, 9,975 children and their families were active to the department. As part of its responsibilities, DCYF is charged with planning, developing and promoting the implementation of new resources and programs that will meet the needs of seriously emotionally disturbed children and children with functional development disabilities. DCYF must coordinate these efforts with other state departments and agencies to meet the needs of this population.

As part of the phased implementation of the MFP demonstration, the department will move forward with increased services and supports to assist with transitioning children back to their homes and communities. The MFP demonstration is complimentary to the current work already underway by the department to expand the capacity of home and community-based providers through the development of a statewide System of Care for children and families. Within the larger System of Care, DCYF will assist the children identified through this demonstration to return to their community with community-based services that support the child and help the

family to care for the child. Children and families will be fully involved in decision-making and the selection of services needed, including both formal and non-formal supports.

As was mentioned previously in the MFP application, DCYF will be part of a second phase of MFP implementation to occur soon after implementation begins for the initial populations. By using a phased approach to implementation, DCYF will be able to ensure that adequate services, staff, procedures and protocols, quality assurance, and financial management mechanisms are in place prior to the initiation of MFP reimbursement.

Target Population

Through the MFP demonstration, DCYF will facilitate the discharge of children and youth placed in the department's care and custody who are ready for discharge to a community setting from a qualified institutional setting [refer to Table 1 for a list of specific institutions]. The children and youth must also meet the following criteria:

- Be age 6 through 20;
- Meet serious emotional disturbance (SED) or developmental disability (DD) clinical criteria [Appendix K-1 and K-2];
- Be ready for discharge to a community setting, including home, relative, foster care, shared living arrangement, or supervised apartment setting, with an array of community-based services;
- Have parent(s) or other responsible caregiver with physical custody committed to supporting and participating in MFP

- Be able to reside and remain in the community with the availability of an appropriate package of services designed to address the multiple presenting needs;
- Have a viable and consistent living arrangement.

Qualified Institutional Setting Transitioned From

Children and youth will be eligible for MFP services that are residents in qualified out-of-state and in-state residential programs, including Psychiatric Residential Treatment Facilities (PRTFs) and other Institutions for Mental Disease (IMDs), and acute care psychiatric hospitals [please refer to Table 1 for a list of specific programs]. The department utilizes three in-state IMDs and a range of out-of-state IMDs as a less restrictive setting than an acute inpatient psychiatric hospital or as an alternative for children who would otherwise languish in an acute psychiatric hospital.

The Department has verified that almost all of the facilities identified as meeting MFP qualified setting criteria are accredited by the Joint Commission, COA, CARF or another appropriate accreditation body. For a small number of out-of-state facilities, DCYF has requested but not yet received verification of accreditation. DCYF will continue to seek proof of accreditation from these remaining facilities.

Table 1: Qualified Institutions

QUALIFIED DCYF MFP INSTITUTIONS	
STATE	FACILITY NAME
Alabama	Alabama Clinical Schools
Florida	Plantation Nursing and Rehabilitation Center
Georgia	Laurel Heights Hospital
	UHS of Savannah, LLC: Coastal Harbor Treatment Center
Massachusetts	Brandon Residential Center
	Cardinal Cushing Centers
	Devereux School
	Fall River Deaconess Home
	Eagleton School Inc.
	Evergreen Center
	Germaine Lawrence School
	Hillcrest Educational Center: Intensive Treatment Center
	Hillcrest Educational Center
	Justice Resource Center: Centerpoint
	Justice Resource Center: Cohannet Academy
	Justice Resource Center: Pelham Academy
	Justice Resource Center: Swansea Wood School
	Justice Resource Center: Meadowridge School
	Justice Resource Center: Van Der Kolk Center Glenhaven
	Justice Resource Center: Berkshire Meadows
	Learning Center for the Deaf: Walden School
	Institute for Development Disabilities
	Protestant Guild for Human Services: Learning Center
	Stetson School
Walker Home for Children Inc.	
Whitney Academy Inc.	
New Hampshire	Lakeview Neurorehabilitation Center
North Carolina	Old Vineyard Youth Services of Keystone
Pennsylvania	Pennsylvania Clinical Schools
Rhode Island	Bradley Psychiatric Hospital- Children’s psychiatric unit
	Butler Hospital – Children’s psychiatric unit
	Harmony Hill School
	North American Family Institute: Alternatives
	St. Mary's Home for Children
South Carolina	ABS New Hope Charlestown
	Palmetto Lowcountry Behavioral Health
	Palmetto Pee Dee Behavioral Health
Tennessee	Hermitage Hall
Vermont	Bennington School

Qualified Community Setting Transitioned To

Through MFP, Children and youth will be transitioned to appropriate community settings. This could include being reunited at home with caregivers or being placed in a DCYF-authorized “kinship” home, non-relative foster home, or a supervised apartment setting. The latter settings generally involve one to two youth residing together in a multi-apartment building with case management, supervision, and supportive services provided by a contracted provider. The goal of a supervised apartment placement is to allow older youth to acquire the skills necessary to live independently with the least amount of restrictions. All of the qualified MFP community settings – from reunification with family to foster family setting to supervised apartments – will need a variety of specialized services to support the child or youth and family during the transition period from the institutional setting.

Services

As stated earlier, the needs of children and youth transitioning from a psychiatric hospital or an in-state or out-of-state IMD will differ from adults and persons with disabilities described in Phase I. Certain HCBS services described in this section will be slightly different than described in the main body of this MFP Demonstration Application. DCYF in collaboration with DHS will continue to refine the following Services section.

DCYF is currently in the process of completing and issuing an RFP for lead partners who will support a unified System of Care and provide wraparound services to children and families involved with the department. The System of Care and wraparound services will be grounded in family “voice and choice” and, along with being family-driven and youth guided, will be home

and community-based; strength-based and individualized; culturally and linguistically competent; integrated across systems; connected to natural helping networks; and data-driven and outcomes-oriented. As DCYF develops the MFP demonstration, it plans to fully integrate MFP into the System of Care and wraparound services so as to foster further growth in maintaining children and youth with their families and/or communities in the least restrictive settings.

The children and youth targeted for inclusion in the MFP demonstration will need intensive, community-based services, including services and supports for parents or other caregivers. Through the MFP demonstration, DCYF plans to provide these services when not otherwise available, as integrated into the wraparound process. DCYF is currently seeking to expand the availability of these evidence-based services.

Qualified HCBS

The following list includes qualified HCBS that DCYF will offer to eligible children and youth as part of DCYF's implementation phase of the *Rhodes to Home* MFP demonstration. All of these qualified HCBS services will be provided under the MFP grant during the 365-day demonstration period at the enhanced MFP FMAP and after the end of the 365-day period at the standard FMAP. These services currently constitute core and preventive services under Rhode Island's Global Waiver.

Core and Preventive Services

- **Homemaker:** Services that consist of the performance of general household tasks (e.g. meal preparation and routine household care) provided by a qualified homemaker when the individual regularly responsible for these activities on behalf of a child or youth is temporarily absent or unable to manage the home or a youth is unable to care for him or herself. Homemakers shall meet such standards of education and training as are established by the state for the provision of these activities.
- **Environmental Modifications (Home Adaptations):** Those physical adaptations to the private residence and/or vehicle of the child or youth or the family, as required by the child or youth's wraparound/care plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the child or youth to function with greater independence in the home. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant.
- **Day Supports:** Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the individual to attain or maintain his/her maximum functioning level and are coordinated with any other services identified in the person's individual plan. Many day supports provided through DCYF may involve intensive home-based services that include daily face-to-face contact with a behavioral modification specialist. Day supports may also include skills development training for children and youth and the families caring for them in order to promote social and emotional health for the target child. Emergency behavioral health

services may be provided to support the maintenance of the child/youth and family in the community.

- **Supportive Employment:** Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supportive employment services are provided at a work site where a person without disabilities is employed, the activities only related directly to the child or youth shall be included in this service. This service allows youth to be provided with supports from a vocational specialist in a work setting as related to their wraparound/care plan.
- **Supported Living Arrangements:** Includes personal care and services, homemaker, chore, attendant care, and medication oversight (to the extent permitted under state law) provided in a private home by a principal care provider who lives in the home. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Supported Living Arrangements. Older youth who reside in a supervised apartment setting may receive personal care and services, chore, case management services, medication oversight, attendant care and companion services. A contracted agency will provide case management and services to these youth.
- **Participant Directed Goods and Services:** Services, equipment or supplies not otherwise provided through the Global Waiver or through the Medicaid State Plan that address an identified need, are in the approved wraparound/care plan, and meet the following requirements: the item or service would decrease the need for other Medicaid services; promote inclusion in the community; and/or increase the person's safety in the home setting. The funds may be utilized to access supports designed to improve and

maintain a child or youth's opportunities for membership in the community, socialization, and enrichment as detailed in their wraparound/care plan.

- **Supports for Consumer Direction (Supports Facilitation):** Focuses on empowering children and youth and the families caring for them to define and direct personal assistance needs and services. DCYF will provide supports for consumer direction primarily through the High Fidelity Wraparound model that is being implemented system-wide. Wraparound engages, guides and supports, rather than directs and manages, youth and families through the service planning and delivery process. A family services care coordinator counsels, facilitates and assists in the development of a wraparound/care plan that includes formal and informal services and supports designed to assist a child or youth to live in a family or community-based setting.
- **Case Management:** Services that assist children and youth and the families caring for them in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for ongoing monitoring of the provision of services included in the child or youth's wraparound/care plan. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and review of care plan on an annual basis and when there are significant changes in child and youth circumstances.

New Qualified HCBS

In addition to the above core and preventive services, DCYF will provide the following services through MFP and after the 365-day demonstration period for eligible children and youth and their families as benefits children:

- **Peer Mentoring Services** will be offered by DCYF to youth with disabilities or eligible parents and foster parents caring for children or youth transitioned from an appropriate IMD following a 90 or more day stay. Peer mentoring will be available to youth and parents prior to, during, and following the transition from a qualified MFP institution. The Peer Mentor will function as a youth or family support partner and will be an adult with a disability or a parent or other caregiver who has successfully confronted issues similar to those faced by parents who are resuming fulltime care for children and youth who are involved with DCYF and MFP eligible. The Peer Mentor will participate in the development of the wraparound/care plan; assist in referring to or arranging for the required services and supports; keep in regular contact with children and caregivers to assess service provision and needs; link participant to required services and supports; identify and report critical incidents, breakdowns in 24-hour back-up system and other problems to DCYF; and serve as an educator, mentor, and coach throughout the demonstration period and thereafter, as required.
- **Respite:** A service provided to children or youth unable to care for themselves that is furnished on a short-term basis because of the absence or need for relief of the parents or other caregivers who normally provide care for the child or youth. Medicaid Federal Financial Participation is not claimed for the cost of room and board, as all respite services under this waiver are provided in a private home setting, which may be in the

participant's home or occasionally in the respite provider's private residence, depending on family preference and case-specific circumstances. When an individual is referred to a DCYF-certified respite agency, a respite agency staff person works with the family to assure they have the requisite information and/or tools to participate and manage respite services. The individual/family will already have an allocation of hours that has been recommended and approved by DCYF. These hours will be released in six-month increments, and the individual/family will determine how they wish to use these hours. Patterns of potential usage might include intermittent or occasional use; routine use of a few hours each week; planned weekends away; a single block of hours that might allow the rest of the family to spend a few days together, or some combination of the above. The individual's/family's plan will be incorporated into a written document that will also outline whether the individual/family wants help with recruitment, the training needed by the respite worker, the expectations of the individual/family relative to specific training and orientation to the home, and expectations relative to documenting the respite worker's time. Each participant in the waiver may receive up to 100 hours of respite services in a year. Additional hours may be available for urgent situations, at the discretion of DCYF. (Under the Global Waiver, RI is already authorized to provide respite services.)

Demonstration Services Under Consideration

The following services will be provided to MFP participants through DCYF during the 365-day demonstration period but will not be available after the conclusion of the 365- day period for eligible children and youth.

- **Community Transition Services:** Non-recurring set-up expenses for children and youth who are transitioning from a qualified institution to a qualified setting in the community. Allowable expenses are those necessary to enable a parent to establish a basic household to include the child or for a young adult to live on his or her own that does not constitute room and board.
- **Enhanced respite services:** Short-term overnight or daytime care designed to provide clinically appropriate care for high-need SED or DD children or youth and reduce the substantial stress for caregivers generated by the provision of constant care to the individual receiving MFP services. Respite agencies will be selected in collaboration with the youth and caregiver(s). Respite services can be offered in the youth's home, out of the home, or in a licensed facility, such as a therapeutic foster home or group residence. Respite services cannot be provided in an acute inpatient psychiatric hospital. The individual/family will determine the allocation of hours that are needed in the wraparound/care plan. This allocation must be reviewed and approved by DCYF and cannot exceed 100 hours per year unless needed due to urgent circumstances. As with regular respite services, the individual/family will determine how they wish to use these hours.
- **Transition Coordinators** will provide the transition services for the DCYF qualified population transitioning into a community setting. They serve as the point person for the

child/youth participant and his/her family during the 365-day demonstration period to ensure a successful and lasting transition. Transition Coordinators will participate in the development of the wraparound/care plan; assist in referring to or arranging for the required services and supports; conduct a home “readiness review”; maintain regular contact with participants and their families to assess service provision and needs; link participants and families to required services and supports; identify and report critical incidents, breakdowns in the 24-hour back-up system and other problems to the appropriate MFP administration at DCYF and to the proper state authorities; and serve as an educator, mentor, and coach throughout the demonstration period. Transition coordinators only provide services to transitioning or transitioned participants 100 percent of their time. For reimbursement, Transition Coordinators will be considered an administrative expense and reimbursed at 100 percent during the 365-day demonstration period.

- **Non-Medical Transportation** will be provided to assist the MFP child or youth population to transition into and successfully remain in the community for the 365-day eligibility period. Non-medical transportation will only be provided to transitioned children and youth and to their caregivers, if children cannot travel alone. These services will be used for numerous activities to ensure that the child or youth successfully remains in the community and include, but are not limited to, moving to a transition residence; receiving required human and social services identified in the wraparound/care plan; visiting family, friends and other individuals that are part of the participant’s support system, or attending community recreational, cultural and civic events. Non-medical transportation will be considered an administrative expense critical to the MFP

participant transitioning into the community and essential for DCYF to exceed the benchmarks. Non-medical transportation will be considered an administrative expense, 100 percent reimbursed by CMS for the 365-day demonstration period.

- **Housing Specialist** will provide assistance to older youth and/or a child or youth's caregiver/family in accessing affordable housing in order to secure viable and consistent living arrangements that can accommodate the child or youth. Additionally, the Housing Specialist will promote and advocate for the youth and/or family in accessing public housing that would support the transition plan.

Criteria and Process to Identify Individuals for Transitioning

The Community Services and Behavioral Health Division (CSBH) of DCYF currently reviews all residential placements requests from DCYF staff. CSBH assigned staff review the status of any youth placed in an out-of-state and in-state facility through meetings with DCYF Family Service Division and Juvenile Justice Division staff and via monthly reports from Placement Solutions, a contracted provider that DCYF uses for utilization management of youth placed in out-of-state facilities.

As a natural extension of its current duties, CSBH will monitor and oversee the referral process and access to MFP services. CSBH will receive MFP referrals from DCYF staff working directly with children and youth, as well as generate its own referrals when an appropriate referral is identified through regular CSBH monitoring duties. Referral packets will include a referral form, MFP eligibility determination form [please see Appendix K-1 and K-2 for draft SED and DD forms], release of information form, and any other necessary information

pertaining to the child, such as clinical assessments, psychological and psychiatric evaluations, medical reports, discharge summaries, etc. CSBH staff and/or other designated DCYF MFP staff will review referrals to assess if the child is eligible for MFP and/or other services.

Once the referral is identified as appropriate for MFP, then the case will be assigned to a Transition Coordinator who will schedule a meeting to discuss MFP and services with the youth (if appropriate developmentally), parents/guardians, current placement providers and assigned DCYF worker. This Transition Assessment meeting will become part of the wraparound process following the implementation of the department's System of Care.

During the Transition Assessment meeting, the MFP team will explore with the youth and parent/guardian the following topics:

- **Residential Stay** including the admission reason(s), prior placement setting(s), and the decision-making process of placement at the program, including the reason for this particular facility selection.
- **Services and Benefits** receiving in the current program and what needs to be transitioned to the community. This includes exploration of any additional supports from family and friends and likes and dislikes about the facility or service and will need to identify social and recreational activities that the youth participates in and interest in moving out of the facility.
- **Child or Youth's and Family's transition plans**, such as where he/she will live, past experiences in living at home or with another caregiver, what assistance is needed for transitioning, what major concerns or fears about transitioning home and into the

community are present, and what real or perceived barriers to return to home and community life exist. These discussions must fully involve family who will be caring for the child or youth and address any challenges that may be present among family members. Transition plans must be strength-based

- **Areas related to a Successful Transition**, including the child or youth being eligible for Medicaid/MFP; the availability of affordable housing for youth or guardian(s)/caregiver(s); existing financial resources and the ability to manage finances; legal or criminal issues for youth and their guardian(s)/care giver(s), ability to access primary and specialty medical and behavioral health care, and the child or youth's and caregiver's existing support system, including natural supports. It is important to assess the youth's understanding of their needs and their family's awareness and skills to promote and maintain "healthy" lifestyles. Furthermore, the consumer and their family's connection to the community, as shown by their natural supports being present and active, are viewed as critical to successful transition

The Transition Assessment Team at DCYF, as convened and facilitated by the Transition Coordinator, will further explore with the child or youth and family/guardian the appropriateness and desirability of transitioning to a community setting. MFP staff will need to communicate with the assigned DCYF worker and discuss the appropriateness of the child or youth transitioning to a community. Transition meeting will also be used to present and discuss beneficiary rights and responsibilities, reinforce that participation in MFP is strictly voluntary and will not affect eligibility to any public or medical assistance program, and discuss potential cost sharing responsibilities. The Transition Assessment Team will have additional

conversations with the beneficiary and his/her parent or guardian so that they may make an informed decision, as necessary.

In addition to statutory child welfare responsibilities, DCYF is also charged with delivering and overseeing behavioral health services for Medicaid-eligible children and youth who need more intensive behavioral health services than those offered by the community and private health plans. Typically, these children and youth are referred to DCYF by their parent(s)/guardian(s) and/or psychiatric hospitals seeking an out-of-home placement. The DCYF intake unit receives a request for a voluntary placement of the child/youth from a guardian. Many of these requests occur because of a lack of flexible community-based service packages that would provide intensive services to the child or youth and family to preserve the family. As part of DCYF's implementation phase of MFP, the department will develop a MFP Transition Coordinator position that will coordinate with DCYF Intake workers and local psychiatric hospitals (specifically Bradley Hospital and Butler Hospital) for referrals of eligible MFP children. This MFP Transition Coordinator will meet with the child/youth, their family or guardian(s), hospital staff, current medical providers, local education agency, and other involved stakeholders to assess the service needs for the child or youth and the appropriateness of MFP services. Accessing MFP services following direct referrals from Bradley or Butler Hospital will allow the child or youth to transition sooner to their community with intensive services.

Assuring Minimum Residency Requirements of 90 Consecutive Days

Beneficiary eligibility will be checked in the InRhodes Medicaid Eligibility System and DCYF's statewide child welfare information system (RICHIST). The MMIS Claims System will be checked to determine that claims were, in fact, during the 90-day period. If a child was not

Medicaid eligible for the entire 90-day period, then proof of 90-day residency in the institution will be sought through RICHIST or from the institution.

Process to Ensure that Participants Eligible for Medicaid for at Least One Day Prior to Transition

The child's eligibility will be verified through the InRhodes Medicaid Eligibility System by the Transition Coordinator or another DCYF CSBH staff member.

Process for Determining Required Services and Supports as well as Participant Readiness for Transition

The MFP Transition Coordinator will complete a comprehensive assessment upon receipt of a referral from CSBH, or CSBH designee, for MFP intake. This assessment will contain information from the child or youth, guardian(s), medical providers, current primary DCYF assigned staff and current placement provider. A copy of the Placement Solutions Risk Assessment results will be forwarded to the Transition Coordinator (Placement Solutions performs utilization management under contract with DCYF). Upon completion of a family meeting for Transition Assessment the MFP Team will review the assessment and team meeting plans and incorporate into the wraparound/care plan for the child or youth. The MFP Transition Team (Coordinator, Peer Mentor), assigned DCYF staff, designated CSBH staff, Medicaid beneficiary (child or youth), family/guardians, facility's clinical staff, the beneficiary's primary care provider and other medical/behavioral health specialists involved in the case will determine whether the child or youth is appropriate for transitioning and what MFP services are needed, as identified in the wraparound/care plan.

The wraparound/care plan (please see Appendix K-3 for a draft plan) will address any risk factors and appropriate interventions to minimize the risk. The wraparound/care plans will include specific goals, provider frequency, method of delivery, duration of services; and service provider. It should also identify formal and informal supports for the child or youth and his/her family. This wraparound/care plan must identify who is responsible for the service and completing referrals. An emergency back up plan will include the child or youth's and the caregiver's identified natural supports and the services listed in the wraparound/care plan that will be utilized during crises or other emergencies. DCYF children and youth may also access a 24-hour hotline for behavioral health supports via the KidsLink Emergency Services Network, the DCYF RI Child Abuse hotline, and the assigned DCYF staff.

The designated Transition Coordinator, or Peer Mentor if involved and appropriate, will conduct a review of readiness of the services prior to all discharges from the qualified programs. The Transition Coordinator or Peer Mentor serves as the point person for the child and youth and family, if involved, during the demonstration period to ensure a successful and lasting transition. They will communicate on a regular basis with the assigned DCYF staff member and/or wrap team members. They will: (1) telephone contact the child or youth or parent/caregiver within the first 24-hours of discharge and conduct home visits within 10 days of transition, and every month thereafter, to assure that medical, behavioral health, human service and support needs are being met, (2) contact the child or youth (if developmentally appropriate), parent/caregiver, or other designated representative within 24-hours after receiving a request or telephone call, (3) consult with wraparound/care team members about changes in the child or youth's status or needs to revise the wraparound/care plan, (4) ensure that the child or youth has access to a primary care

provider and that the provider receives medical information about the child or youth, (5) arrange for additional medical, behavioral health, human and support services, as required, (6) identify appropriate social and community opportunities for the child or youth including day programs, recreational activities, or cultural and socialization opportunities, (7) educate the child and youth (as appropriate) and caregiver about the 24-hour back-up plan, (8) assess on an ongoing basis the adequacy of the back-up and safety plan and make improvements to ensure the child or youth's health and safety are met, and (9) report critical incidents, such as abuse, neglect and exploitation, to the proper authorities for investigation and resolution.

Re-enrollment of Beneficiaries After Completed MFP and Re-institutionalized

Any child or youth who is an MFP participant and has been institutionalized for less than 30 days during the twelve-month period may simply re-enter the demonstration program.

If the child or youth is institutionalized for more than 30 days during the twelve-month period, then the participant will be disenrolled from the MFP demonstration. These children or youth may, however, re-enroll in the programs without meeting the 90-day residency requirement. For such children or youth, the wraparound/care plan will be reviewed and modified, as appropriate, to ensure that the appropriate services and support are provided to obviate the need for further institutionalization. DCYF will reenroll children or youth whose 12 months in the demonstration have passed but who have not used up their 365-days of MFP services because of being in an institutional setting during the 12-month period.

Until further guidance from CMS is received, DCYF will not reenroll an individual back into the MFP demonstration that has received the 365-days of eligible MFP services but is then re-institutionalized.

Procedures and Processes to Ensure Patients/Families Received Information to Make Informed Decisions

The Transition Coordinator and assigned DCYF staff member (when feasible for out-of-state facilities) will meet with the Medicaid-eligible child or youth and his/her family/guardian before beginning the assessment process. This meeting will be exploratory in nature to determine beneficiary needs and desires as well as to obtain family members/guardians perspective about the appropriateness and desirability of transitioning to a community setting. During this meeting, the Transition Assessment Team will reinforce the voluntary nature of the demonstration and provide information to enable a youth and parent/caregivers to make an informed decision. The Assessment Team will review with the beneficiary and their representatives a brochure about MFP that includes key elements of the demonstration (e.g. enrollees rights and responsibilities, voluntary nature of the demonstration, the process for enrolling in the demonstration, supports and services provided to ensure a successful transition, and key requisites for remaining in a community setting). The Assessment Team will respond to all questions and have interactive conversations with the child or youth, as appropriate, and their parents or caregivers to ensure that all involved have sufficient information to make informed decisions about participation. If the beneficiary is an appropriate MFP candidate, the Assessment Team will have further conversations with the child or youth, as appropriate, and his/her parent or caregiver, if involved, to ensure that they have sufficient knowledge about options available to them and an understanding of the MFP demonstration, as necessary. As part

of the overall wraparound process for children and families, the child and youth and their families will be integral members of the assessment and wraparound/care plan team.

Once part of the MFP program and successfully transitioned, the designated Transition Coordinator or Peer Mentor will become the primary contact with the child and youth and family or foster family for MFP purposes. This ongoing involvement will be designed to ensure a successful and lasting transition, and the Transition Coordinator and/or Peer Mentor will work closely with the DCYF worker, if involved, to coordinate and plan services. As previously noted, Transition Coordinator and Peer Mentor will conduct a home visit within 10-days of transition. The participant's parent or caregiver will be invited to attend this meeting. This initial visit will serve two purposes: (1) to ensure that the initial phase of the transition is proceeding as planned and to determine if any changes are needed in the wraparound/care plan or if additional services/supports are required, and (2) to provide a more in-depth education about key MFP demonstration elements and how to access them. Topics that will be addressed at this visit include: (1) the proper use of the 24-hour back-up system; (2) the identification and reporting of critical incidents related to abuse, neglect and exploitation; and (3) service or care issues that are not being met.

The Transition Coordinator or the Peer Mentor will provide and review with the beneficiary the 24-hour Back-Up System approach described previously (i.e. contact participant's own back-up and designated service providers). If these back-up system steps do not work, then the beneficiary will be instructed to contact their designated Transition Coordinator or Peer Mentor who will follow-up to determine why the steps failed and what appropriate changes should be

made in the back-up system or in the wraparound/care plan or with other available community resources. The Transition Coordinator or Peer Mentor will report these instances to the DCYF CSBH administrator or CSBH designee and the involved DCYF worker so that all failures are accounted for and to determine if system-wide changes may be necessary. The Family Community Advisory Board (FCAB), convened by DCYF, will also provide a feedback mechanism for stakeholders to notify DCYF of issues, since MFP services will be incorporated into the scope of the FCAB. The Family and Community Advisory Board (FCAB) is comprised of state and regional boards and includes members of youth and families, community partners and stakeholders.

The Transition Coordinator or the Peer Mentor will provide and review with the child or youth, as appropriate, and parent/caregiver a Critical Incident Reporting Fact Sheet that describes how to recognize and report incidences of abuse, neglect and exploitation. The participant and/or family will be instructed to notify their Transition Coordinator, who in turn will notify the proper state authorities for investigation, as well as telephone the proper state authority directly to report such incidents.

RI law requires any person who has reasonable cause to believe that a person under 18 years of age has been abused to report it to the Department of Children, Youth and Families hotline at 1-800-742-4453 (1-800-RI-CHILD). The DCYF Protective Services Unit is responsible for investigating complaints of child abuse of Rhode Islanders 18 and younger by a family member, caregiver or person with duty of care. Abuse may include physical, emotional, sexual, or abandonment. In addition, The Rhode Island Department of Health has authority to investigate

and adjudicate complaints of “unprofessional conduct” as the licensing agency for health care providers and most non-behavioral health facilities.

The Transition Coordinator or Peer Mentor will notify the designated CSBH staff of all critical incidences to assess whether there are patterns that require system-wide changes in the demonstration. Both the 24-hour backup system and critical incidences will be described in the MFP Participant Handbook.

Outreach/Marketing/Education

DCYF will work with DHS to develop and disseminate outreach and marketing materials to educate possible children and youth and families who may participate in the program and DCYF and private provider staff on MFP. In conjunction, DCYF will develop a training program for DCYF and private provider staff working with possible eligible populations. Work on these materials will begin immediately following the award of a demonstration grant to include DCYF. All materials will be developed in English, Spanish, and any other languages that are deemed necessary to promote inclusion in MFP.

MFP Projected Positions

DCYF, in collaboration with DHS, will develop descriptions of staff positions that will be required to successfully implement and operate the Phase II of the MFP Demonstration for the DCYF population.

Budget

As part of the second phase of MFP implementation in Rhode Island, DCYF will work with DHS to fully develop and submit a detailed budget to CMS that will include complete projected Qualified HCBS, Demonstration HCBS and Administrative costs.

Appendix K-1
RHODE ISLAND DEPARTMENT OF CHILDREN, YOUTH and FAMILIES

Determination of Need for Transitional Services for MFP

Children with Serious Emotional Disturbances (SED)

CHILD'S NAME (LAST, FIRST, MI.):		
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:

INSTRUCTION: Based on the following criteria, indicate whether the child, in your clinical opinion, meets the Level of Care requirements for participation in the MFP Transitional service option. This form must be completed on an annual basis. This form is part of the Enrollment and Reauthorization Packet that must be sent to CSBH at DCYF for authorization.

1. CRITERIA

- The child/youth is between 0 and 20 years of age at initial enrollment. For MFP re-enrollment and continued eligibility through reauthorization, participants must be under the age of 21.
- The child/youth must be in placement for a duration of **90+ consecutive days** at the highest level of care such as psychiatric hospital, high end residential facility.
- The child/youth meets the definition for Serious Emotional Disturbance (SED). Criteria listed on next page.
- The child/youth demonstrates complex health or mental health care needs (*relies on Mental Health care, nursing care, monitoring or prescribed medical or mental health therapy in order to maintain quality of life*). Receives (or appears to need to receive) medical or mental health therapies, care or treatments that are designed to replace or compensate for a vital functional limitation.
- The child/youth appears to be capable of being cared for in the community if provided access to, but not limited to, the following services: Health Care Integration; Skill Building; Day Habilitation; Prevocational Services; Special Needs Community Advocacy and Support; Planned Respite; Supported Employment Services; Family/Caregiver Supports and Services; Crisis Avoidance, Management and Training; Intensive In-home Supports and Services; Immediate Crisis Response Services; Crisis Respite; Adaptive and Assistive Equipment; and Accessibility Modifications.
- The child/youth appears to have services and support needs that cannot be met by one agency/system.

In addition, the child/youth:

- Currently resides in an institutional placement, including a hospital and has resided in such a hospital for at least 90 consecutive days **OR**
- Has been determined by DCYF CSBH Division or authorized designee, in the absence of the MFP, the child/youth would require hospital/highest level of care.

2. DETERMINATION

- YES**, This child is determined to meet the need for Hospital Level of Care to be eligible to receive services in this program.
- NO**, This child does NOT meet the Level of Care criteria to be eligible for services in this program (Specify).
- Is not between ages of 0 and 18,
 - Is not in substitute care for 90+ days,
 - Does not meet the definition for Seriously Emotionally Disturbed,
 - Does not require, or is not in imminent risk of needing psychiatric inpatient services,
 - Has not demonstrated complex health or mental health needs,
 - Is not capable of being cared for in the community, if provided access to MFP services,
 - Has service and support needs that can be met by a single agency/system,

CHILD'S NAME, (LAST, FIRST, MI.):		
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:

3. SIGNATURES (Include printed name, signature, professional title and date.)

1. **Non-State Individual Signature:** A physician (MD or DO), registered nurse (licensed in State), licensed independent clinical social worker (LCSW), licensed psychologist, licensed mental health counselor (LMHC), or nurse practitioner.

PRINTED NAME:	SIGNATURE: X
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TITLE:	DATE:
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2. **Regional Director or Designee:**

PRINTED NAME:	SIGNATURE: X
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3. Authorizing CSBH Designee:	DATE:
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SED Criteria

- A. Designated mental illness diagnoses are a DSM-IV-TR diagnosis (or ICD-9-CM equivalent) other than (i) alcohol or drug disorders, (ii) developmental disabilities, (iii) organic brain syndromes, or (iv) social conditions (V-Codes). V-Code 61-20 Parent Child problem is included for eligibility for services in clinic treatment programs servicing children with a diagnosis of emotional disturbance. ICD-9-CM categories and codes that do not have an equivalent in DSM-IV-TR are not included as designated mental illness diagnoses.

AND

- B. Extended Impairment in Functioning Due to Emotional Disturbance means a child has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional problems must be moderate in at least two of the following areas or severe in at least one of the following areas:
- a. Self-care (personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
 - b. Family life (capacity to live in a family, family like environment or small group setting; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
 - c. Social relationships (establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
 - d. Self-direction/self-control (ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
 - e. Learning ability (school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

OR

- C. Current Impairment in functioning with Severe Symptoms means a child must have experienced at least one of the following within the past 30 days.
- a. Serious suicidal symptoms or other life-threatening self-destructive behaviors; or
 - b. Significant psychotic symptoms (hallucinations, delusions, bizarre behaviors); or
 - c. Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
 - d. Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Appendix K-2

Rhode Island Department of Children, Youth & Families Determination of Need for MFP Services Children/Youth with Developmental Disabilities

CHILD'S NAME (LAST, FIRST, MI.):		
DATE OF BIRTH:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MEDICAID CIN#

INSTRUCTION: Based on the following criteria, indicate whether the child/youth, in your opinion, meets the eligibility to participate in MFP Transitional services option. This form must be completed on an annual basis. This form is part of the Reauthorization packet that must be sent to CSBH at DCYF.

DATES OF EVALUATIONS:	PHYSICAL:	SOCIAL:	PSYCHOLOGICAL:
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RECIPIENT ELIGIBILITY CRITERIA

1.	DIAGNOSIS: <input type="checkbox"/> <i>A. MENTAL RETARDATION</i> <input type="checkbox"/> <i>C. AUTISM</i> <input type="checkbox"/> <i>E. CEREBRAL PALSY</i> <input type="checkbox"/> <i>B. EPILEPSY</i> <input type="checkbox"/> <i>D. NEUROLOGICAL IMPAIRMENT</i> <input type="checkbox"/> <i>F. OTHER</i>	
2.	SEVERE BEHAVIOR PROBLEM: <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i> FREQUENCY: <input type="checkbox"/> <i>Daily</i> <input type="checkbox"/> <i>Weekly</i> <input type="checkbox"/> <i>Monthly</i> <input type="checkbox"/> <i>Has occurred in the past 12 months</i>	
3.	HEALTH CARE NEED: A. <i>Medical condition which requires daily individualized attention from health care staff</i> B. <i>Self injurious behavior which necessitates monitoring and treatment</i> C. <i>Deficit in self-care skills</i> 1. No self-help skill	<input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i>
4.	ADAPTIVE BEHAVIOR DEFICIT: A. COMMUNICATION: 1. Individual has no expressive or receptive language 2. Individual has some expressive or receptive language B. LEARNING: 1. I.Q. cannot be determined (certified untestable). 2. I.Q. of less than 50. 3. I.Q. of 50-69 C. MOBILITY: 1. Individual is non-ambulatory and totally dependent on others for moving from one place to another. 2. Individual has some mobility skills but needs others assistance and training to increase his/her capacity for moving about. D. CAPACITY FOR INDEPENDENT LIVING: 1. Client is completely dependent on others for all household activities. 2. Individual needs assistance or training to perform tasks to be contributing member of a household. E. SELF-DIRECTION: 1. Individual exhibits weekly misbehaviors requiring individualized programming. 2. Individual is completely dependent on others for management of his/her personal affairs within the general community. 3. Individual exhibits monthly misbehaviors requiring individualized programming. 4. Individual needs assistance or training for management of his/her personal affairs within the general community.	<input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i>

SIGNATURE OF REVIEW Physician/Licensed Psychologist:	PRINT NAME:
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AGENCY ADDRESS:	CITY:	STATE:	ZIP
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OFFICE USE ONLY

MFP eligibility (<input type="checkbox"/> 90+days in qualified placement; <input type="checkbox"/> DD diagnosis; <input type="checkbox"/> ready for discharge to qualified community setting): <input type="checkbox"/> YES or <input type="checkbox"/> NO			
NAME:	URE:	DATE:	
TITLE:	DIVISION/AGENCY:		

Appendix K-3
MFP Wraparound/Care Plan

DRAFT