G-Initial Visits

G-110 Initial Visits for Community Residents

SC must:

- Contact the individual and/or responsible representative within three (3) working days of receiving the Support Coordination Choice and Release of Information form to schedule a face-to-face initial meeting to complete the assessment.

- Conduct a face-to-face meeting with the individual and/or members of his/her support network within seven (7) working days of receiving the Support Coordination Choice and Release of Information form to complete the assessment process.

  NOTE: The planning team may include anyone requested by the participant, but at a minimum will include the individual, his/her responsible representative (if applicable) and the SC.

During this meeting, the SC will:

- Introduce him/herself to the individual
- Get to know the individual
- Provide information about the waiver program and eligibility processes
- Gather any necessary information
- Explain the waiver program Community Choices Waiver (CCW) or Adult Day Health Care (ADHC) Waiver
- Explain all available services
- Explain Self-Direction (for CCW only)
- Review and explain OAAS Rights and Responsibilities as a waiver participant

- Explain the range of services and supports available in the waiver program
- Complete the Initial Minimum Data Set-Home Care (MDS-HC) (Refer to Initial Assessments for Individuals Residing in the Nursing Facility procedures & MDS-HC Manual)
- Ask/complete the Degree of Difficulty Questions (if applicable)
- Ask the individual about his or her support network (paid and unpaid) currently in place to determine how his/her preferences are currently being met
- Explain the need for these paid supports to be supplemented with natural or paid supports, since waiver services are not available 24 hours per day
- Explain that the state is responsible for reasonably assuring the health and welfare of individuals with provision of these paid supports in conjunction with natural and other paid supports
- Answer questions as simply and clearly as possible so the individual understands the program requirements and services

SC will refer to Assessment section.

G-120 Initial Visits for Nursing Facility Residents

During this initial meeting for NF Transition individuals, the SC will **ALSO** explain the following:

- My Place LA (i.e. Money Follows the Person-MFP) and if interested in participating, have individual sign the MFP Informed Consent form.
- Transition services do not cover ongoing costs for housing and other basic preferences (e.g. groceries, utilities, etc.).
- More services may be available initially when he/she comes out of the NF, but services may be decreased after he/she transitions out into the community (because services depend on participant's preferences).

SC must:

- Meet with appropriate NF staff (e.g. Social Worker, Director of Nursing, etc.), ombudsman and family, as applicable, to review records and gather information for determining if the individual's needs can be met outside of the NF. This information may include, but is not limited to:

    - Does he/she have supplemental, natural and/or other paid supports available?

    - Does he/she have housing?

    - Does he/she have means for meeting other basic needs? (Discuss income and budget)

Sources of information may include but are not limited to: the ombudsman, the Minimum Data Set-Nursing Facility (MDS-NF) assessment, the Minimum Data Set-Home Care (MDS-HC) assessment (Refer to Assessment section), progress notes and orders from all applicable disciplines.

Once all assessment information is gathered, if it appears that the individual's health and welfare CANNOT be reasonably assured, the SC will:

- Compile supporting documentation and a detailed narrative regarding the inability to reasonably assure health and welfare and submit to SC supervisor.

NOTE: Plan of Care (POC) does not have to be completed or submitted. However, based on the information obtained through the assessment and/or other sources, the narrative should address the issues described above (e.g., housing, adequacy of paid and unpaid supports, etc.) in detail why it is not felt that transition is NOT an option for the individual to transition.

SC supervisor will review and approve closure/denial.

SC/SC supervisor will submit all documentation to RO for review.

RO will email all information for review to the Service Review Panel (SRP).

If SRP determines that the individual's health and welfare cannot be reasonably assured, RO will send a denial letter with appeal rights to the individual and a copy to the SCA.

NOTE: If POC was completed, RO will complete POC Action Section indicating date of SRP Referral and SRP findings.

After the 30 days for appeal rights have passed and the individual did NOT appeal, RO will complete a 142 (Refer to 142 procedures) indicating "Not Approved" and email a copy to Medicaid office, DMC and the SCA.

SC will close the case in CMIS.

Once all assessment information is gathered and it appears that the individual's health and welfare can be reasonably assured, the SC will proceed with the MDS-HC assessment (if not already completed). If MDS-HC assessment completed, then the SC will proceed with the Plan of Care (POC) development (Refer to Initial POC Development for Individuals Residing in the Nursing Facility procedures).

SC will assist the individual with completing the following applications if applicable:

- Housing
- Social Security
- Medicaid

NOTE: Even if the individual is approved for waiver services and is still residing in the NF (due to housing issues, unable to obtain required documents, extended hospital/rehabilitation stay, etc.), the SCA should continue to follow-up and work with the individual and/or Money Follows the Person (MFP) Transition Coordinator (TC) on identified barriers to assist in transitioning him/her into the community.

Once the barrier is resolved, the SC will proceed with the POC development (Refer to Initial POC Development for Individuals Residing in the Nursing Facility procedures).

NOTE: If the individual is residing in a NF in one region, but would like to transition to the community in another region, the SCA in the region in which he/she is currently residing in the NF will process the waiver case until he/she moves out of the NF and to the other region. The SCA assisting with the transition can work with MFP TCs and both RO as needed.