G-Initial Visits

G-110 Initial Visits for Community Residents

The Support Coordinator (SC) must:

- Contact the individual and/or responsible representative within 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.

    - If the individual and/or representative (responsible or legal) are not reachable within 3 working days, the SC should document the attempt(s) on the Support Coordination Contact Documentation (SCD). An activity code of 00—No Service Provided with a Type of Contact of either 1—In Person or 2—Telephone should be entered.

      NOTE: Three documented contact attempts on 3 separate, consecutive working days from the date of linkage will meet the SCA 3 day initial contact requirement.

- Conduct a face-to-face meeting with the individual and/or members of their support network within 7 working days of the initial 3-day contact.

    - If the individual and/or responsible representative are not able to schedule the face-to-face meeting within 7 working days of the initial contact, the SC should document the attempt(s) in the Support Coordination Contact Documentation (SCD).

NOTE: The support network may include anyone requested by the participant, but at minimum must include the individual, their responsible representative (if applicable), and the SC.

During this meeting, the SC will:

- Introduce themselves to the individual;

- Provide information and explain the waiver program including all waiver services, for either Community Choices Waiver (CCW) or Adult Day Health Care (ADHC) Waiver, and the eligibility processes;

- Gather all necessary information;

- Offer all available community services;
- Explain Self-Direction (CCW only);
- Review the OAAS Rights and Responsibilities as a waiver participant;
- Explain the range of services and supports available in the waiver program;
- Complete the Initial interRAI Home Care (iHC) (Refer to Sections G—Initial Visits and H—Assessments and Reassessments of this Manual, and the interRAI Manual);
- Ask/complete the Degree of Difficulty Questions (if applicable);
- Ask the individual about their support network (paid and unpaid) currently in place to determine how their preferences are currently being met;
- Explain the need for waiver supports to be supplemented with natural, community or other paid supports, since waiver services are not available 24 hours per day;
- Explain that the Louisiana Department of Health (LDH) is responsible for reasonably assuring the health and safety of individuals with provision of these paid supports in conjunction with natural and other paid supports; and
- Answer questions as simply and clearly as possible so the individual understands the program requirements and services.

SC will refer to Section H—Assessments and Reassessments of this Manual.

G-120 Initial Visits for Nursing Facility Residents

During the initial meeting for Nursing Facility (NF) Transition individuals, the SC will **ALSO** explain the following:

- My Place Louisiana (i.e., Money Follows the Person-MFP) and if interested in participating, obtain the individual's signature on the MFP Informed Consent form.
- Transition services do not cover ongoing costs for housing and other basic preferences (e.g., groceries, utilities, etc.).

- Some services, including Transition Services, may be available upon, and shortly after transition, but not available post-transition.

- Services may be decreased after the participant transitions out into the community, depending on person's preferences, need and availability of natural supports and community resources.

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 the individual have supplemental, natural and/or other paid supports available?

  - Does the individual have housing?

  - Does individual 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 (MDS) 3.0 for Nursing Facilities assessment, the interRAI Home Care (iHC) assessment, progress notes and orders from all applicable disciplines.

- Contact the transition coordinator to determine transition activities already initiated, information gathered by the transition coordinator, and to review the individual's needs.

  Sources of information may include verbal/written information (Transition Assessment and Plan if My Choice Louisiana) provided by the Transition Coordinator.

Once all information is gathered and it appears that the individual's health and welfare **can** be reasonably assured, the SC will proceed with the iHC assessment (if not already completed).
Once completed, the SC will proceed with the Plan of Care (POC) development (Refer to Section K—Plans of Care-- Initial POC Development for Individuals Residing in the Nursing Facility of this Manual).

The SC will assist the individual with completing the following applications if not yet completed:

- Housing
- Social Security
- Medicaid

NOTE: Even if the individual is approved for waiver services and is still residing in the NF (due to waiting for housing, 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) or My Choice 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 the individual is currently residing will process the waiver case until the individual transitions from the NF to the other region. The SC assisting with the transition should work with MFP TCs and both ROs as needed.

Once all 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: The 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 (e.g., adequacy of paid and unpaid supports, etc.) in detail and explain why transition does NOT appear to be an option for the individual.

SC supervisor will review and approve closure/denial.

SC/SC supervisor will submit all documentation to Regional Office (RO) and the Transition Coordinator (TC) for review.

RO and TC determine who (RO or TC) will submit a referral to OAAS's Service Review Panel (SRP). Both RO and the TC will discuss cases prior to submission to SRP and include both recommendations.

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

After the 30 days for appeal rights have passed and the individual did NOT appeal, RO will request an electronic 148W for closure from the SC.

SC will submit an electronic 148W for closure to RO. (Refer to HCBS Waiver 148W Instructions, OAAS-ADM-13-016).

RO will:

- Process the 148W, electronically signing, saving and uploading to the 148W database.
- Send a copy of the signed/processed 148W to the DMC and SCA.
- Complete a BHSF form 142, Medicaid Notice of Medical Certification (Refer to 142 instructions, OAAS-ADM-13-017) and email a copy to Medicaid, DMC and the SCA.