



COMMISSIONER
Chris Traylor

Supporting Documents for Relocation Efforts

Attached is a compilation of various documents that provide guidance and responsibility regarding Texas' Money Follows the Person Relocation Efforts.

(Compiled November 2009)

C:\Documents and Settings\sashman\My Documents\Relocation Contractors\Documents for Relocation Efforts Nov 2009.doc

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COMMISSIONER
Adelaide Horn

November 1, 2007

To: All Nursing Facility Administrators

Re: Information Letter # 07-107
Relocation Contractor Staff Access to Nursing Facility Residents and Clinical Records and Access by Nursing Facility Residents to Other Representations of Community-based Organizations

This Information Letter updates Provider Letter # 04-18 issued on June 18, 2004.

The Promoting Independence Initiative (Initiative) was developed in response to the United States Supreme Court Ruling in *Olmstead v. L.C.*, 110 S. Ct. 2176 (1999), and is supported by two Governor's Executive Orders (GWB 99-2 and RP 2002-13) and state legislation (Senate Bill 367, 77th Legislature, Regular Session, 2001). The purpose of the Initiative is to provide enhanced community options so individuals will have more residential choices in receiving their long term services and supports.

Money Follows the Person (MFP) is a significant policy resulting from the Promoting Independence Initiative. MFP allows nursing facility (NF) residents to move back into the community to receive services without being on an interest list or using a community "slot" to access services in the community.

One aspect of MFP is the creation of "relocation specialist" activities. Relocation specialists perform outreach and education activities for NF residents and identify individual residents who want to access community services through MFP. In addition, relocation specialists can assist in the facilitation and coordination of transition activities into the community.

The Department of Aging and Disability Services (DADS) contracts with relocation contractors; the contractors hire relocation specialists to perform activities related to community transition. As contractors of the state, relocation specialists have the authority to enter a NF and work with residents to explore interest in MFP; *this activity is not considered solicitation.*

NF administrators must allow relocation specialists access to their facilities and support them in this activity. Relocation specialists must provide adequate identification. DADS expects each NF administrator and NF staff to support and assist in all MFP activities, including the relocation specialists, relocation specialist activities, and transitional services.

It should be noted that NF residents are under no obligation to speak to relocation specialists. NF residents must be *provided with the opportunity* to interact with the relocation specialists to obtain further information, should they so desire.

Relocation specialists will be visiting nursing facilities throughout the state. Upon entering a NF, a relocation specialist must identify themselves, request to speak to the Administrator or the person designated in charge in the absence of the Administrator, and explain the purpose of the visit.

Relocation specialists should be granted access to visit with residents, along with the resident's family members or other representatives with the resident's approval, and have access to clinical records and any other documentation, with the resident or resident's legal representative's written approval, and those activities and processes necessary to facilitate the residents' transition into a community setting.

DADS contracts with the following organizations to provide relocation services for nursing facility residents, including children residing in a nursing facility:

Relocation Contractor	DADS Region(s)	Subcontractors
ARCIL INC. (512) 832-6349	Regions 4, 5, 7	<ul style="list-style-type: none"> • Crockett Resource Center for Independent Living • East Texas Center for Independent Living • Heart of Central Texas Independent Living Center • Resource, Information, Support, and Empowerment
The Valley Association for Independent Living, Inc. (956) 668-8245	Regions 8, 11	The Center on Independent Living (COIL)
Houston Center for Independent Living (713) 974-4621	Region 6	None
LIFE/RUN-1 (806) 795-5433	Regions 1, 2	Panhandle Independent Living Center (PILC)
LIFE/RUN-5 (806) 795-5433	Regions 9, 10	VOLAR Center for Independent Living ABLE
North Central Texas Council of Governments (NCTCOG) (817)695-9193	Region 3	<ul style="list-style-type: none"> • REACH • Community Council of Greater Dallas' Area Agency on Aging • United Way of Metropolitan Tarrant County's Area Agency on Aging • Texoma Council of Governments' Area Agency on Aging of Texoma

In addition, DADS' NF rules under 40 Texas Administrative Code (TAC) §19.413, *Access and Visitation Rights*, require the facility to allow other representatives of community-based organizations access to their facility to visit residents contingent upon the individual's permission. This visitation may be to provide health, social, legal or other

services to an individual but may be subject to reasonable restrictions. Also, 40 TAC §19.402, *Exercise of Rights*, states that the resident has the right to exercise their rights as a resident at the facility and as a citizen of the United States and to be free of any retaliation from exercising those rights.

MFP is an important DADS' policy initiative that requires the cooperation of all of our contractors and community-based organizations. It is important that all parties work together professionally to promote the NF resident's quality of life and individual choice of residential setting to receive their long term services and supports. As stated above with regard to the relocation contractors, NF residents are under no obligation to speak to representatives of any community-based organizations. NF residents must be *provided with the opportunity* to interact with these representatives to obtain further information, should they so desire.

Representatives from these organizations are expected upon entering a NF, to identify themselves, request to speak to the Administrator or the person designated in charge in the absence of the Administrator, and explain the purpose of the visit.

If you have any questions about this letter, Promoting Independence, or the MFP policy, please contact Steven Ashman, MFP Program Specialist, at (512) 438-4135.

Sincerely,

[signature on file]

Tommy Ford
Section Director
Institutional Services

TF:mg



TEXAS
Department of
Human Services

COMMISSIONER
James R. Hine

June 28, 2004

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To: All Nursing Facility Administrators

Re: Provider Letter #04-18 – Relocation Services Contract Staff Access to Nursing Facility Residents and Clinical Records

The purpose of this letter is to remind providers that the Texas Department of Human Services (DHS) Relocation Services contract staff are visiting nursing facilities. They should be granted contact with residents and access to clinical records.

DHS has contracted with the following organizations for conducting relocation services for nursing facility residents, including children, as part of the DHS Promoting Independence plan:

- Accessible Communities, Inc. -- Regions 6, 8 and 11;
- ARCIL, Inc. -- Regions 3 and 7;
- Crockett Resource Center for Independent Living, Inc. -- Regions 4 and 5; and
- LIFERUN, Inc. -- Regions 1, 2/9 and 10

Relocation services are being provided statewide.

Promoting Independence was developed in response to the United States Supreme Court ruling of *Olmstead v. Zimring*, the Governor's Executive Order 99-2, issued to the Texas Health and Human Services Commission, and Senate Bill 367 from the 77th Legislature.

Upon entering nursing facilities, contract staff will identify themselves, request to speak to the person in charge, and explain the purpose of the visit.

If you have questions about the content of this letter, please contact Debbie Hightower at 512/438-2561.

Sincerely,

[signature on file]

Marilyn Eaton
Long Term Care Services

ME:dh

From Relocation Contractor RFP

2. Identification and Assessment Process

After a request is made, the contractor must make initial contact with the individual within 14 calendar days of a request for service. Within each region, the contractor will perform an evaluation of needs and an assessment process that will be used to either transition Medicaid eligible adults and children from a nursing facility to the community, or to document the reasons transition is not feasible. DADS will approve the evaluation of needs and assessment process tools before implementation. These should be used in developing person/family directed plans and in arranging resources to make relocation possible. The contractor must make the tool, process and instructions for its use, available to DADS.

From the Relocation Contractor RFP

5. Transitional Grants

Individuals who reside in nursing facilities and wish to receive their long-term services and support in a community setting may need assistance setting up residence in the community. DADS will provide one-time start-up funds to help an individual establish a community residence. These start-up funds will be available through TAS and TLC. TLC may be used for expenses that are not covered by Medicaid or other long-term services programs. Start-up funds available through TAS are not allowed for individuals relocated to Adult Foster Care or Assisted Living facilities.

The start-up funds can be used for expenses directly related to moving, including but not limited to paying others to move household belongings; rent deposits; utility deposits; cooking utensils; other moving-related expenses and household start-up costs. Available TAS funds must be accessed before TLC funds can be used, as TLC funds are to complement, not supplant, TAS funds.

The contractor will be required to administer the transition grants and implement a tracking and reporting systems in accordance with agency guidelines and the terms of the contract. The maximum independent amounts of the one time transition grants for TAS and for TLC is \$2,500 total on each per individual, for a maximum of \$5,000 total based on the needs of the individual.

South Texas

Valley Association for Independent Living (VAIL)
3012 North McColl Road
McAllen, Texas 78501
956.668.8245 FAX 956.631.7914

The Center on Independent Living (COIL)
2525 Ladd Street
Lackland AFB (San Antonio), Texas 78236-5323
210.671.7956 FAX 210.671.7953

Personal Data				
Name of Relocation Specialist:				
Name:			Date:	
Other Name:			Phone:	
SS#:			Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		U.S. Citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Language:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		D.O.B.:	(Age):
	<i>Specify:</i>			
Date of Admission:		Previous NF Admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# of Previous Admissions?
TILE #:		Medicaid #:		Medicare #:
Legal Guardian?	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Financial Only <input type="checkbox"/> Medical Only			Specify/Name:
Income:	<input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> SS Retirement <input type="checkbox"/> VA <input type="checkbox"/> Pension <input type="checkbox"/> Other : _____			Amount(s):
Guardian Name:				Guardian Phone:
Physician's Name:				Physician's Phone:
Nursing Facility Information				
Nursing Facility Name:			NF Phone:	
Nursing Facility Address:			NF Contact:	
City, St., County, Zip:			NF Contact/ Title:	
Do you wish to relocate back into the Community? <input type="checkbox"/> Yes <input type="checkbox"/> No				
People Important to Consumer				
Family/Friends Advocates:			Phone:	
Family/Friends Advocates:			Phone:	

Medical Condition and Professional Care Needs

Diagnosis:

Secondary Diagnosis:

Current Health Problems, Describe:

Medications: List (attach sheet if additional space is required)

Mental Health Treatment:

- Hospitalization Medication Counseling
 Substance Abuse Treatment

Reasons for Entering NF:

- Treatment of Medical Condition, Illness, or Injury
 Family Conflict or Loss of Family Support
 Health or Personal Care Problems while in Community
 Unable to Return Home from Hospital/Rehabilitation Facility
 Difficulty in Maintaining Community Residence
 Financial Problems
 Other

(Check All That Apply)

Explain Below:

Medical Treatment Required Prior to Transition:

Personal Care Requirements:

- | | |
|--|--|
| <p><input type="checkbox"/> Transfers to/from Bed, Wheelchair, Etc.</p> <p><input type="checkbox"/> Help with Walking or Using Wheelchair, Cane, or Other Mobility Device</p> <p><input type="checkbox"/> Help with Cooking or Eating</p> <p><input type="checkbox"/> Help with Using the Toilet</p> <p><input type="checkbox"/> Help Taking Medication</p> <p><input type="checkbox"/> Help with Bathing or Maintaining Personal Hygiene</p> <p><input type="checkbox"/> Help with Shopping or Money Management</p> <p><input type="checkbox"/> Requires Bowel or Bladder program</p> | <p><input type="checkbox"/> Help with Cleaning and Home Maintenance</p> <p><input type="checkbox"/> Supervision to Prevent Injury or Getting Lost</p> <p><input type="checkbox"/> Receiving Therapies (Specify)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Speech/Language/Audiology <input type="checkbox"/> Psychological <input type="checkbox"/> Occupational <input type="checkbox"/> Respiratory <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Cognitive <input type="checkbox"/> Physical <input type="checkbox"/> Radiation <input type="checkbox"/> Dialysis <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A |
|--|--|

Previous Personal Care Arrangements

Community Care Services:

- Previous received home health. Agency used: _____
 - Did Not Previously Receive Home Health or Attendant Services
 - Services Were Managed by the Consumer
 - Services Were Managed by a Parent or Family Member
 - The Home Health Agency Denied or Stopped Services
- Explain: _____

Housing

Previous Living Arrangements:

(Check All That Apply)

- Return to Previous Residence
- Foster Care or Alternate Family
- Rent Apartment or House
- Assisted Living Facility
- Live with Relatives in Their Home
- Other (specify) _____
- Service Animal

Desired Living Arrangements:

(Check All That Apply)

- Return to Previous Residence
- Foster Care or Alternate Family
- Rent Apartment or House
- Assisted Living Facility
- Live with Relatives in Their Home
- Other (specify) _____

Desired Location
City/County:

Accessible? Yes No

Accessibility Requirements:

- Ramps
- Grab Bars
- Raised Commode
- Roll In Shower
- Wide Doorways
- Visual Smoke Alarms
- Other _____
- N/A

Apply for:

- Olmstead Voucher
- Section 8
- HVP (Project Access)
- Public Housing
- N/A

Problems with Rental History

- Past Eviction
- Criminal History
- Poor Credit
- Poor Rental History
- N/A

Comments:

Financial

Needs Prior to Relocation:

- Establish Guardianship
- End/Change Guardian
- Establish Bank Acct.
- Establish Payee
- Transfer SS Benefits
- Establish Direct Deposit

Ongoing Debts That Impede Relocation

- Landlord (\$)
- Housing Authority (\$)
- Utilities (\$)
- Child Support (\$)
- Mortgage (\$)
- Phone (\$)
- Other (\$)
- Credit Cards (\$)
- N/A

Anticipated Problems:

Supports Needed to Relocate

Supports That Can Be Provided by a Family Member or Community:

- | | | | |
|--|---|---|-----------------------------------|
| <input type="checkbox"/> Guardian | <input type="checkbox"/> SSA Payee | <input type="checkbox"/> Financial Management | <input type="checkbox"/> Cooking |
| <input type="checkbox"/> Health Management | <input type="checkbox"/> Transportation | <input type="checkbox"/> Personal Care | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Moving Assistance | <input type="checkbox"/> Furniture | <input type="checkbox"/> Household Items | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Home Maintenance | <input type="checkbox"/> Personal Care Management | | |

Comment:

Transportation

Available?
(Check all That Apply)

- Yes No
- | | | |
|---|--|--|
| <input type="checkbox"/> Personal Vehicle | <input type="checkbox"/> Fixed Route Bus | <input type="checkbox"/> Para-transit (Certified?) |
| <input type="checkbox"/> Family Members/Friends | <input type="checkbox"/> Taxi | <input type="checkbox"/> Other _____ |

Assistance Needed:

- | | |
|--|---|
| <input type="checkbox"/> Training for Fixed Route Buses | <input type="checkbox"/> Establishing Eligibility for Para-Transit |
| <input type="checkbox"/> Escort | <input type="checkbox"/> Scheduling Para-transit |
| <input type="checkbox"/> Transferring In/Out of Vehicles | <input type="checkbox"/> Locate Medical Transportation |
| <input type="checkbox"/> Locate Non-Medical Transportation | <input type="checkbox"/> Orientation & Mobility Training <input type="checkbox"/> N/A |

Government And Private Supports

Obtain Identification:

- | | | |
|---|--|--|
| <input type="checkbox"/> Medicaid Card | <input type="checkbox"/> State Identification Card | <input type="checkbox"/> Birth Certificate |
| <input type="checkbox"/> Driver's License | <input type="checkbox"/> Social Security Card | <input type="checkbox"/> N/A |

Food:

- | | | | | |
|--|-------------------------------------|--------------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> Meals On Wheels | <input type="checkbox"/> Food Banks | <input type="checkbox"/> Food Stamps | <input type="checkbox"/> WIC | <input type="checkbox"/> N/A |
|--|-------------------------------------|--------------------------------------|------------------------------|------------------------------|

Financial Assistance:

- | | | | | |
|-------------------------------|---|--|--------------------------------|------------------------------|
| <input type="checkbox"/> TANF | <input type="checkbox"/> Discounted Phone | <input type="checkbox"/> Energy Assistance | <input type="checkbox"/> Other | <input type="checkbox"/> N/A |
|-------------------------------|---|--|--------------------------------|------------------------------|

Activities:

- | | | | | |
|---|---|--------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Counseling/Support | <input type="checkbox"/> Church | <input type="checkbox"/> Recreation | <input type="checkbox"/> Senior Center | <input type="checkbox"/> IL Skills |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Continuing Education | <input type="checkbox"/> Other _____ | <input type="checkbox"/> NA | |

Needs TAS?

- Yes No

Need TLC?

- Yes No

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Moving Costs? | <input type="checkbox"/> Utility/Security Deposits | <input type="checkbox"/> Home Items |
|--|--|-------------------------------------|

Comments:

Assistive Technology Required

Equipment:	<input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Power Wheelchair <input type="checkbox"/> Commode Chair <input type="checkbox"/> Shower Chair <input type="checkbox"/> Shower Bench <input type="checkbox"/> Lift Equipment <input type="checkbox"/> Brace/Prosthesis <input type="checkbox"/> Lifting Chair <input type="checkbox"/> Other _____ <input type="checkbox"/> Cane, Walker, Crutch <input type="checkbox"/> Equipment for Transfers <input type="checkbox"/> N/A
Bed:	<input type="checkbox"/> Regular <input type="checkbox"/> Semi-Automatic <input type="checkbox"/> Fully-Automatic <input type="checkbox"/> Therapeutic Mattress <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A
Eating Utensils:	<input type="checkbox"/> I.V. Supplies <input type="checkbox"/> Modified Utensils <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A
Visual aids:	<input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Magnifier <input type="checkbox"/> Braille Signage <input type="checkbox"/> N/A
Communication aids:	<input type="checkbox"/> Hearing Aid <input type="checkbox"/> TTY Device <input type="checkbox"/> Modified Phone <input type="checkbox"/> Visual Smoke Alarm <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A
Cognitive/Memory aids:	<input type="checkbox"/> Planner/Organizer <input type="checkbox"/> Programmable Watch <input type="checkbox"/> Medication Reminder <input type="checkbox"/> N/A
Medical Alert aids:	<input type="checkbox"/> Bracelet <input type="checkbox"/> Medical Alert Service (Lifeline) <input type="checkbox"/> VitAlert <input type="checkbox"/> Tags <input type="checkbox"/> N/A

Signatures

I will explore opportunities to relocate to a community living arrangement.

Relocation Specialist Signature:

Consumer Signature:

Consumer Legal Guardian Parent/Guardian

Comments:

Transition to Life in the Community (TLC) — Application and Plan

Applicant Information

Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Medicaid No.	Social Security No.
Name of Nursing Facility			Date Admitted	Estimated Date of Discharge
Facility Address (Street, City, State, ZIP Code)				
Facility Mailing Address (if different from street address above)				
Check one for each of the following questions:				
Is the applicant a Texas Medicaid recipient who resides in a licensed nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has the applicant ever received TLC benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Money Follows the Person Demonstration

Is the applicant participating in the Money Follows the Person Demonstration? Yes No

Complex Needs of Individual – See Page 6.

Authorized Representative Information (if applicable)

Name of Person Applying on Behalf of Applicant	
Relationship to Applicant (Check One)	
<input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Other (Specify): _____	
<input type="checkbox"/> Guardian (Specify type, court appointing and effective dates): _____	
Authorized Representative's Mailing Address (Street, City, State, ZIP Code)	
Home Area Code and Telephone No.	Business Area Code and Telephone No.

Information on Person Assisting the Applicant with the Application

Name of Person Assisting the Applicant	
Relationship to Applicant (Check One)	
<input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Other (Specify): _____	
<input type="checkbox"/> Guardian (Specify type, court appointing and effective dates): _____	
Mailing Address (Street, City, State, ZIP Code)	
Area Code and Telephone No. Where Person Assisting Can Be Reached	Name of Agency (if applicable) and Title

Temporary Rental Assistance

Temporary rental assistance is provided as a social service intended to help individuals move to community settings by helping pay rent until subsidized housing is available. Temporary rental assistance payments are included in the \$2,500 TLC maximum benefit and will reduce the availability of TLC funds for other relocation expenses. Temporary rental assistance is not available to individuals returning to their own homes, the home of a family member or spouse, or other settings in which rent payments by the individual were not required before entry into the nursing facility. Parents of minor children (individuals under 18 years old) may not receive temporary rental assistance on behalf of their children. The suggested temporary rental assistance is the difference between the monthly rental bill and 30 percent of the applicant's monthly income. See Item i in the Agreements section of this application.

Do you intend to request temporary rental assistance? Yes No

If yes, include information in Services Requested portion of this application.

Source of Ongoing Services

Identify the accepted ongoing community-based service.				
Program Name	Accepted for Services		ISP Date or Date Services to Start, if Known	Program Contact Person (Name, Agency, Area Code and Telephone No.)
	Yes	No		
Medically Dependent Children Program	<input type="checkbox"/>	<input type="checkbox"/>		
Deaf-Blind Multiple Disabilities Program	<input type="checkbox"/>	<input type="checkbox"/>		
Community Living Assistance and Support Services	<input type="checkbox"/>	<input type="checkbox"/>		
Community Based Alternatives	<input type="checkbox"/>	<input type="checkbox"/>		
Integrated Care Management	<input type="checkbox"/>	<input type="checkbox"/>		
DADS Community Care Program	<input type="checkbox"/>	<input type="checkbox"/>		
Other Medicaid-Funded Community Program—Specify:	<input type="checkbox"/>	<input type="checkbox"/>		

Shared Household Information

Check Yes or No on each of the following questions:

Do you intend to share a residence? If **No**, skip to next section. Yes No

Will the person(s) with whom you plan to live also need assistance with relocation expenses? Yes No

Do you want to pay this person's relocation expenses with your TLC funds? Yes No

If Yes, include those expenses in the Services Requested portion of this application.

Income and Resources

<p>1. List all expected monthly income, both earned and unearned:</p> <p>Earned Income: \$ _____</p> <p>Unearned Income (specify source):</p> <p>Social Security \$ _____</p> <p>SSI \$ _____</p> <p>Railroad Retirement \$ _____</p> <p>Veterans Administration \$ _____</p> <p>Other Retirement \$ _____</p> <p>Interest Income \$ _____</p> <p>Other \$ _____</p> <p>Total Monthly Income: \$ _____</p>	<p>2. List all resources (that is, cash, stocks, property, vehicles, etc.):</p> <p>Resources:</p> <p>Cash \$ _____</p> <p>Savings..... \$ _____</p> <p>Stocks..... \$ _____</p> <p>Bonds \$ _____</p> <p>Real Property; Value \$ _____</p> <p>Automobiles, Trucks \$ _____</p> <p>Equipment \$ _____</p> <p>Other Personal Property..... \$ _____</p> <p>Total Resources: \$ _____</p>
---	--

Of the resources listed in Column 2, describe which, if any of these, are available to help the applicant move from the facility.

Community Services and Assistance

Resources used before applying for TLC benefits: Transition Assistance Services Family Church Social Organization

Other:

Projected Living Expenses

List projected living expenses and any balances owed in the community setting:

Item or Service	Cost Per Month	Balance Owed
Rent or Mortgage	\$ _____	\$ _____
Utilities	\$ _____	\$ _____
Telephone	\$ _____	\$ _____
Food	\$ _____	\$ _____
Transportation	\$ _____	\$ _____
Toiletries	\$ _____	\$ _____
Other (list)		
.....	\$ _____	\$ _____
.....	\$ _____	\$ _____
.....	\$ _____	\$ _____
Payments (list purpose and amounts)		
.....	\$ _____	\$ _____
.....	\$ _____	\$ _____
.....	\$ _____	\$ _____
.....	\$ _____	\$ _____
Total Monthly Expenses:	\$ _____	\$ _____

Provide any other information that explains how you will be able to afford to live in the community after the TLC funds are spent.

Check the Residence Relocation Type:

- | | |
|--|---|
| <input type="checkbox"/> Rental – Apartment/House | <input type="checkbox"/> Senior Retirement Center |
| <input type="checkbox"/> Assisted Living Facility (licensed) | <input type="checkbox"/> Own Home/Family |
| <input type="checkbox"/> Independent Living Center | <input type="checkbox"/> Shared Residence |
| <input type="checkbox"/> Other (Specify): | |

This application must be signed to be accepted by DADS. Before you sign, be sure each answer is complete and accurate and that you have read the information on each page.

With few exceptions, you have the right to request and be informed about the information that DADS obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask DADS to correct information that is determined to be incorrect (Government Code, §§552.021, 552.023, 559.004). To find out about your information and your right to request correction, contact your local DADS office.

Whoever obtains or attempts to obtain, by fraudulent means, financial assistance, services or treatment to which he is not entitled, will be deemed guilty of a state or federal offense and upon conviction may be fined or imprisoned or both.

My answers to all the preceding questions, and the statements I have made, are true and correct to the best of my knowledge and belief.

Signatures

_____ Signature-Applicant	_____ Date		
If applicant is unable to sign, two witnesses to his or her mark must sign and date.			
_____ Signature-Witness	_____ Date	_____ Signature-Witness	_____ Date

Signature — Authorized Representative

If applicant is unable to sign or make his or her mark, the authorized representative must sign and date on behalf of the applicant.

_____ Signature—Authorized Representative	_____ Date
--	---------------

DADS State Office Use Only

DADS Approval

Name	Title	Date
------	-------	------

Complex Needs of Individual – Check the appropriate box (or boxes) to indicate complex need(s).

- Residence in a nursing facility for six months or longer?
- Behavioral health issues – mental health and/or substance abuse?
- Need for assistance to move to rural setting that is not an established household?
- Lack of a community residence and/or affordable or accessible housing?
- Need for assistance with three or more activities of daily living (ADLs)?
- Intellectual and/or developmental disabilities with other cognitive disabilities?
- Ventilator dependent (not partial)?
- Other (Specify):

[Skip to content](#)

Texas Department of Aging and Disability Services
Transition Assistance Services Orientation Handbook
Revision: 06-0
Effective: May 22, 2006

Section 1000

TAS Overview

TAS Purpose

Transition Assistance Services (TAS) assists Medicaid recipients who are nursing facility residents discharged from the facility to set up a household in the community. TAS is only available to nursing facility residents who are discharged from the facility into certain waiver programs. TAS is not available to residents moving from a nursing facility who are approved for any of the following waiver services:

- Assisted living services
- Adult foster care services
- Support family services
- 24-hour residential habilitation
- Family surrogate services

All nursing facility residents who are being discharged into the community under some of the Medicaid waiver programs will be offered TAS by the case manager to establish a household. A nursing facility resident certified for waiver services may receive a one-time TAS authorization of up to \$2,500, if the case manager determines that no other resources are available to pay for the basic services/items needed by the individual. **Example:** Expenses covered by TAS are security and utility deposits, moving expenses and essential furnishings necessary to establish a basic living arrangement.

TAS includes, but is not limited, to payment or purchase of:

- security deposits required to lease an apartment or home, or to establish utility services for the home;
- essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils and food preparation items;
- moving expenses required to assist the individual to move into or occupy the home or apartment; and
- services to ensure the health and safety of the individual in the apartment or home, such as pest

eradication, allergen control or a one-time cleaning before occupancy.

File viewing information.

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Texas Department of Aging and Disability Services
Transition Assistance Services Orientation Handbook
Revision: 06-0
Effective: May 22, 2006

Section 4000

Authorization and Referral Process

The provider agency must accept all individuals of any waiver program who are referred to the provider agency for services.

Step	Action
1	<p>The case manager will:</p> <ul style="list-style-type: none"> • meet with the nursing facility resident and/or the resident's representative to discuss the waiver service array and living arrangement options, and obtain the resident's choice of provider agencies; • work with the resident and/or the resident's representative to identify the essential Transition Assistance Services (TAS) needed under the categories of Deposits, Household Needs and Site Preparation, as found on the assessment form; • determine if other resources are available to purchase the needed services; and • document the identified services/items on the TAS assessment form.
2	<p>The case manager will:</p> <ul style="list-style-type: none"> • finalize and authorize waiver services once the applicant meets all of the eligibility criteria; • contact the applicant to confirm the nursing facility discharge date and the individual's new address in the community; and • notify the individual that he/she is eligible for waiver services, including TAS, and send the individual a waiver eligibility notice.
3	<p>The case manager will send the TAS authorization form and assessment forms to the selected TAS provider agency. The authorization form will include the individual's identifying information (name, address, etc.), the total dollar amount authorized for TAS and the TAS completion date. The assessment form will include the authorized services/items and the corresponding maximum dollar amount authorized.</p>
4	<p>The case manager will notify the TAS provider agency when an individual will not relocate into the community as planned. The case manager will also request that the provider agency not make any TAS purchases. The TAS provider agency can submit a claim for services that</p>

	were already purchased and delivered.
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File viewing information.

**Transition Assistance Services (TAS)
Assessment and Authorization**

- Select applicable program:
- Community Based Alternatives (CBA)
 - Community Living Assistance and Support Services (CLASS)
 - Consolidated Waiver Program (CWP)
 - Deaf-Blind with Multiple Disabilities (DBMD)
 - Medically Dependent Children Program (MDCP)

1. Individual Name	2. Medicaid No.	3. Assessment Date	4. Proposed Date of Discharge
5. Current Nursing Facility Address			6. Area Code and Telephone No.
7. Planned Community Address			8. Area Code and Telephone No.

9. Assessment for TAS

TAS assists Medicaid recipients who are nursing facility residents discharged from a facility to set up a household. TAS is only available to nursing facility residents who are discharged from a facility into a waiver program.

TAS is a one-time benefit of \$2,500 for essential services to relocate to the community.

Does the individual have arrangements for a home or apartment upon discharge from the nursing facility? Yes No

Services Required

10. Deposit Type	Description	Maximum Authorized Amount
Security Deposit		
Electricity		
Gas		
Water		
Telephone		
Other		
Subtotal for Deposits		\$ 0.00

11. Household Items	Description	Maximum Authorized Amount
Furniture/Appliances		
Housewares		
Small Appliances		
Cleaning Supplies		
Other		
Subtotal for Household Items		\$ 0.00

12. Site Preparation Services	Description	Maximum Authorized Amount
Moving Expense		
Pest Eradication		
Allergen Control		
One-Time Cleaning		
Other		
Subtotal for Site Preparation Services		\$ 0.00

13. Totals

Total for Deposits	\$ 0.00
Total for Household Items	\$ 0.00
Total for Site Preparation Services	\$ 0.00
Total	\$ 0.00

Individual's Information (from Page 1)

Individual Name	Medicaid No.
Current Nursing Facility Address	Area Code and Telephone No.
Planned Community Address	Area Code and Telephone No.

14. Individual Statement and Signature

I certify that I have decided to relocate to the community and the items and services listed above are necessary for me to establish a residence in the community. I agree to let the TAS agency I have selected make these purchases for me.

_____	_____
Signature – Individual/Individual's Representative	Date
_____	_____
Signature – Case Manager	Date

15. TAS Provider Selection

The TAS provider has been selected by the individual to purchase the items and services listed on Form 8604. The TAS provider is authorized to make these purchases and bill for the purchases and services, as described in the rules and procedures for TAS within the waiver program.

TAS Provider Name	TAS Vendor No.
Completion Date	Total Amount Authorized

16. DADS Use Only

DADS Staff Name (Type or Print)	Area Code and Telephone No.
Mailing Address	

_____	_____
Signature – DADS Staff	Date of Authorization

17. Individual Signature

I certify that I have received the items and services listed above.

_____	_____
Signature – Individual/Individual's Representative	Date

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Texas Department of Aging and Disability Services
Transition Assistance Services Orientation Handbook
Revision: 06-0
Effective: May 22, 2006

Section 8000

Frequently Asked Questions

- Q:** Can the individual receiving Transition Assistance Services (TAS) services request a specific brand or type of appliance, furniture or other TAS item, even if a similar item can be purchased at a lesser amount?
- A:** Yes, as long as the individual's needs are met within the cost limit.
- Q:** Can the TAS item be placed in someone else's home? For example, the individual is moving in with a daughter and they are requesting bedroom furniture.
- A:** TAS can be used in this situation only when furnishings are not available and are necessary for the individual to be able to transition from the nursing facility.
- Q:** Can TAS replace existing furniture that the individual/individual's representative deems no longer usable?
- A:** TAS can be used only to provide the necessary basic items for the individual to live in the community. If an existing item is truly not usable and the lack of a usable basic/essential item creates a barrier that keeps the individual from returning to the community, then the individual has a need for the item. However, TAS cannot be used for upgrading to a better quality item just because the individual would like new items.
- Q:** What happens to the TAS items if the individual chooses to return to the nursing facility?
- A:** If the individual has left the nursing facility and has possession of the TAS items, the items belong to the individual. The individual is responsible for making any decision regarding the disposition of the TAS items upon returning to the nursing facility.
- Q:** Can security deposits or utility deposits be in someone's name other than the individual?
- A:** No. The deposits must be in the individual's name.
- Q:** Will TAS pay for the deposit on a cell phone if that is the individual's only telephone service?
- A:** Most cell phones do not require a deposit. Since a telephone is considered a basic need, TAS can purchase a telephone, but may not pay for any minutes or services.
- Q:** Can TAS be used to pay for arrears on previous utilities that must be paid before the new service is turned on?
- A:** Yes, only if it is in the individual's name and the individual will not be able to get utilities unless the previous balance is paid.
- Q:** Will TAS pay for pet deposits?

- A: No, TAS will not pay pet deposits, unless the individual has a service animal. If the individual has a service animal, pet deposits can be considered essential to the individual.
- Q: Can TAS be used to pay for repairs (not home modifications) on the individual's dwelling?**
- A: No. TAS cannot be used to pay for repairs.
- Q: Can TAS be used to set up a septic system in rural areas?**
- A: No.
- Q: It appears that the first day of authorization for TAS is the initial eligibility date from the Individual Service Plan/Individual Plan of Care form. The individual should still be in the nursing facility awaiting the completion of TAS and the start of service. Will the provider agency be able to bill for TAS items purchased during this period if nursing facility coverage is still open?**
- A: Yes. The system has been designed for this overlap.
- Q: Does the case manager amend the TAS authorization form only if there is a new item requested, or must the case manager amend the TAS authorization form if there is a change in the price of a specific item?**
- A: The case manager amends the TAS authorization form, Individual Service Plan (ISP), for any valid change requests. If more funds are needed to purchase an item on the estimated cost list, the case manager also makes that change on the TAS authorization form.
- Q: Is there a window of time in which the individual can request additional items on TAS? Implementation material states TAS is "one-time," but then allows for individuals to request additional items. How long after the initial authorization can the individual request additional items under TAS?**
- A: To assist the individual in making a successful transition to the community, the individual may request additional items or seek resolution of a problem until the completion date specified on the TAS authorization form. This date is two days prior to the planned discharge date. The case manager must make every effort to ensure that all basic/essential items are authorized while the individual is still in the nursing facility.
- Q: If the individual requests items under TAS, can the case manager authorize a flat \$2,500?**
- A: No.
- Q: Should the TAS authorization form include the individual's date of birth and Social Security number, since utility companies for deposits usually require this information?**
- A: The case manager must provide any necessary information to the TAS agency. The TAS authorization form requires the individual's date of birth and Social Security number.
- Q: Should a copy of the intake be sent with the TAS authorization?**
- A: To protect the privacy of the individual, a copy of the intake should not be provided to the TAS agency. If any additional information is needed, it should be attached on Form 2067, Case Information.
- Q: Can the TAS agency exceed the amount for a particular item, as long as the amount for the total category is not exceeded? For example, a water deposit is noted for \$100 and an electricity deposit is noted for \$200. It turns out the electric company will only require a \$100 deposit, but the water company raised its deposit to \$150. The total for deposits is still under the \$300 authorized.**
- A: Yes. The TAS agency can exceed the amount for a particular item as long as there are adequate funds authorized. The amounts listed in the guide are estimated, since utility deposits vary widely across the state. The case manager does not need to make a change on the authorization as long as there is adequate money authorized to cover the need.

Q: If the TAS agency finds it needs additional funds in a specific category, but fewer in others, should the case manager change the TAS authorization form?

A: No. The case manager does not change the TAS authorization form as long as the total authorized amount is adequate to cover the costs. However, if the TAS agency identifies a new item required by the individual, then a TAS authorization form is completed, processed as a change and sent to the agency with the additional items and amounts authorized.

Q: Does the agency request a change in the authorization if the amount of one of the items is not enough or if the amount of the categories is not enough?

A: The TAS agency may request a TAS authorization form change if the actual cost exceeds the authorized amount or if a new item/service not previously requested needs to be included.

Q: Long Term Care (LTC) Information Letter No. 04-33 states, "The TAS provider is authorized to purchase only the specific items or services found on the form, within the dollar amount authorized for each item or service." The memo also states the TAS provider may submit separate claims for each item or service. What does each item or service mean?

A: The memo quoted is LTC Information Letter No. 04-33, which was sent to providers from the Provider section. While the TAS agency is usually going to submit only one claim for all services, it can submit a second billing (or third, etc.) for additional items or changes added on a revised TAS authorization form. Examples of items and services include utility/security deposits, moving expenses and essential furnishings necessary to establish a household.

Q: If a TAS individual is moving into an apartment and the apartment requires the first and/or last month's rent as part of the security deposit, can TAS pay this amount?

A: According to the Centers for Medicare and Medicaid Services (CMS), security deposits may be paid as long as:

- this payment is specifically called a security deposit and not rent;
- the payment is for a one-time expense; and
- the amount of the payment is no more than the equivalent of two months rent.

Q: The TAS agency purchases an item or service that has prior approval by the case manager, but the nursing facility resident changes his mind and doesn't leave the facility or dies before being discharged. What does the TAS agency do with the purchased item?

A:

- The TAS agency must attempt to return the item. If the TAS agency receives a full refund, the TAS agency cannot bill for this item.
- If the TAS agency cannot return the item, it must submit a written notice to the case manager. The case manager will contact a local charity and make arrangements for pick-up.
- If the TAS agency can return the item for a partial refund, the TAS agency can bill for the amount it did not get back.

In each of the above cases, the agency can bill for the TAS fee. The case manager indicates the change and provides an explanation on Form 2067, Case Information, submitted with the TAS authorization form.

Q: If a TAS individual has no resources for purchasing food at the time of move-in, can TAS pay for food?

A: No, TAS funds cannot be used for food. The case manager may refer the individual to emergency Supplemental Nutrition Assistance Program (SNAP) or local food pantry resources. Some funding is available through the Transition to Living in the Community (TLC) program. TLC funds are primarily designated for non-waiver individuals, but if a waiver individual has no other resources, TLC may be able to pay for food.

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Q: If an individual is moving from the nursing facility into an apartment, but plans to have a roommate, can TAS pay for (a) the security deposit and (b) furniture and other items the individual will need?

- A:
- a. TAS can pay for the deposit only if the apartment is in the TAS individual's name and no other arrangement has been made with the roommate. This also depends on the timing of the move-in and agreement with the roommate and the apartment. The individual's transition from the nursing facility should not be unduly delayed waiting on the roommate.
 - b. Yes, TAS can pay for furniture and other items that the individual needs. The individual and roommate must decide who will provide the furniture in the shared areas of the apartment. TAS can be used to purchase the items the individual agrees to provide. TAS funds cannot be used to buy furniture that would only be used by the roommate. **Example:** TAS could not purchase two bedroom suites for the individual. The individual may utilize TAS only to meet basic needs required to transition to the community.

[File viewing information.](#)

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COMMISSIONER
Adelaide Horn

June 20, 2007

To: Home and Community Support Services Agencies (HCSSAs) Contracted With the Texas Department of Aging and Disability Services (DADS) to Provide 1915(c) Medicaid Waiver Services Through the Following Programs or Agencies: Community Based Alternatives (CBA), Consolidated Waiver Program (CWP), Deaf-Blind With Multiple Disabilities (DBMD), and Community Living Assistance and Support Services (CLASS) Direct Service Agencies

Subject: Regulatory Services Provider Letter #07-06
Community Services Information Letter #07-06
Clarification of Licensing Rules and Contract Requirements Regarding Accepting Individuals with Complex Needs for Service

This clarification is provided in response to questions about HCSSAs' non-acceptance of individuals for services due to concerns about meeting an individual's needs in the community. **This clarification should not be interpreted as requiring a HCSSA to accept any particular individual for services.**

DADS' mission includes a focus on ensuring self-determination as well as the health and welfare of individuals served in the community. In an effort to ensure individual choice, self-determination, and health and welfare, DADS has put forth several initiatives supporting the Promoting Independence Plan, including the "Money Follows the Person" (MFP) policy. MFP policy allows individuals residing in nursing facilities (NFs) to move into the community without first having to be registered on an interest list for a 1915(c) Medicaid waiver program. As described in HCSSA licensure rules at 40 Texas Administrative Code (TAC) §97.282(f)(1-7), individuals have the right to participate in the planning of their care and must be informed in advance and on an ongoing basis about the care to be furnished and any barriers to treatment.

Over 13,000 individuals have transitioned from NFs using MFP policy since September 2001. In addition to NF residents transitioning to the community, there are potential HCSSA consumers already residing in the community. However, for some potential consumers with complex needs, finding a provider is difficult.

The HCSSA licensure rule most often cited by HCSSAs for non-acceptance of an individual is 40 Texas Administrative Code (TAC) §97.401(b), which states in part:

"The agency must accept a client for home health services based on a reasonable expectation that the client's medical, nursing, and social needs can be met adequately in the client's residence."

However, 40 TAC §97.401(b) goes on to say:

*“An agency has made a reasonable expectation that it can meet a client's needs if, at the time of the agency's acceptance of the client, the client and the agency have agreed as to what needs the agency would meet; for instance, **the agency and the client could agree that some needs would be met but not necessarily all needs.**”*

All HCSSAs must comply with licensure rules at 40 TAC Chapter 97. HCSSAs that contract with DADS to provide 1915(c) Medicaid waiver services must comply with the requirements of their contract to provide waiver services in addition to the licensure rules. In an effort to promote consistency and clarify the intent of HCSSA licensing rules and DADS contracting requirements, DADS' Regulatory Services, Provider Services, and Access and Intake divisions jointly provide the following questions and answers. Individuals described in the following questions and answers are assumed to have the capacity to make informed decisions. Negotiations regarding acceptance of responsibility for an individual who has a legal guardian or legally authorized representative (LAR) must include the guardian or LAR.

Question #1: May a HCSSA accept an individual even though it cannot meet all of the individual's needs?

Answer: Yes. DADS Regulatory Services confirms that HCSSAs may establish agreements consistent with 40 TAC §97.401(b). An individual may express a desire to take responsibility for certain needs or to leave certain needs unmet, rather than have the HCSSA meet all needs. An individual may assume responsibility for certain needs under an “individual responsibility agreement” (IRA). No specific format for the agreement is mandated under DADS contract requirements or HCSSA licensure rules, but it must clearly document which needs will not be met by the HCSSA. The individual must have a clear understanding of what the HCSSA will not do and must confirm agreement by signing the IRA. HCSSA licensure rules at 40 TAC §97.292(a) also require HCSSAs to provide individuals with a “client agreement and disclosure” that includes “services to be provided.” Therefore, even separate from any IRA, HCSSAs must clearly advise individuals as to what services will, and will not, be provided.

Question #2: No format is required for an IRA, but would DADS provide an example?

Answer: Yes, the attached example IRA and instructions may be used for service planning, but providers may also develop their own form as long as it meets the following minimum requirements.

- Identifies the applicant/consumer, provider, and provider representative who negotiated the agreement, including the applicant/consumer's Medicaid Number, Social Security Number, or both
- Includes dated signatures of the applicant/consumer and provider representative
- Documents the identified need for which the applicant/consumer agrees to take responsibility

- Includes any details provided by the applicant/consumer regarding specific plans to meet the need
- Includes a statement describing potential consequences for the applicant/consumer and noting that these consequences were explained to the applicant/consumer

A copy of any IRA must be maintained in the clinical record and sent to the appropriate case manager as supporting documentation for the Individualized Service Plan/Plan of Care. **The attached example IRA does not guarantee immunity from civil or criminal liability.** DADS does not require the use of this example agreement and parties should consult with their legal representation regarding the use and limitations of this or any responsibility agreement.

Question #3: When an individual is served in a 1915(c) Medicaid waiver program, who is responsible for assuring "health and welfare" when an IRA is used?

Answer: The Centers for Medicare and Medicaid Services (CMS) require the State to assure the health and welfare of an individual served in 1915(c) Medicaid waiver programs, which include Community Based Alternatives (CBA), Consolidated Waiver Program (CWP), Deaf-Blind with Multiple Disabilities (DBMD), and Community Living Assistance and Support Services (CLASS). CMS' technical guide for waiver reviews includes the following direction:

"A waiver's design must provide for continuously and effectively assuring the health and welfare of waiver participants. Processes that are important for assuring participant health and welfare include (but are not necessarily limited to):

- *Specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications;*
- *Periodic monitoring of the implementation of the service plan and participant health and welfare;*
- *Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants; and,*
- *Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights."*

Question #4: In a DADS 1915(c) Medicaid waiver program, must every DADS-referred individual be accepted for service?

Answer: No, however, the agency must document and advise the individual of the **specific reason(s)** why it is unable to serve the individual. For example, when an agency has served or is serving an individual with needs similar to the individual being considered for services, it must clearly explain and demonstrate the differences that prevent it from serving the individual under consideration. Citing general licensing regulations such as "40 TAC §97.401(b)" is not sufficient.

For an individual served in CBA or CWP, a registered nurse (RN) is required to complete an assessment to identify needs, including those needs an individual requests to take responsibility for or to leave unmet. If, in the professional judgment of the RN after consulting with the individual, an unmet need would pose a serious threat to the individual's health and welfare, the need must be met. The individual must demonstrate how the identified need will be met by the individual or other resources. If the individual is unable or unwilling to meet the need sufficiently to ensure that his/her health and welfare will no longer be seriously at risk, and the HCSSA believes it cannot meet the need, then the HCSSA may refuse the referral.

In the CLASS program, case management agencies (CMAs) provide case management, while HCSSAs provide the direct services as the direct service agency (DSA). The DSA RN and CMA case manager jointly assess individuals for CLASS eligibility. In DBMD HCSSAs provide both case management and direct services; the DBMD agency RN and case manager jointly assess individuals.

In both CLASS and DBMD, the assessments identify all needs, including needs that might be met by other resources. This includes assessing needs for which an individual requests to accept responsibility, assisting to locate community and other resources to meet those needs, and documenting these arrangements in an IRA when appropriate.

In CLASS the DSA communicates any concerns regarding unmet needs (including those unmet needs that might pose a serious threat to health and welfare) to the individual and the CMA. The CMA reviews and consults with the DSA to determine if a denial of CLASS services is appropriate. The CMA may consult with DADS state office program consultants to explore options and alternatives, including IRAs, prior to issuing a denial of CLASS services. In DBMD HCSSAs also seek resources to address potentially unmet needs. They may also consult with DADS state office program consultants to explore options and alternatives, including IRAs, prior to recommending a denial of DBMD services.

Question #5: What if an individual who negotiates a responsibility agreement with a HCSSA experiences problems related to a need that the individual agreed the HCSSA was not responsible for meeting?

Answer: While 40 TAC §97.401(b) allows HCSSAs to establish agreements with an individual that not all needs will be met, HCSSAs must maintain compliance with relevant licensure rules and contract requirements. In particular, HCSSAs must ensure compliance with 40 TAC §97.288(a), which reads:

*"An agency must adopt and enforce a written policy that **requires effective coordination of care with all service providers involved in the care of a client, including physicians, contracted health care professionals, and other agencies.**"*

When any HCSSA employee, volunteer, or contractor becomes aware of an individual experiencing any significant change in condition or circumstances, the HCSSA must enforce its written policy that requires effective coordination of care with all service providers involved

in the care of the individual. **HCSSAs cannot ignore significant changes in an individuals' condition or situation under an IRA.** HCSSAs may discontinue their participation in an IRA upon consultation with the individual. HCSSAs may also seek assistance from DADS or other case managers to locate appropriate services and supports for an individual when needed. The DADS regional relocation specialist may also be able to help locate additional resources. The HCSSA must clearly document all significant changes, actions taken to help the individual find needed assistance, and any conversations related to revising or discontinuing an IRA.

Question #6: Do DADS contract requirements describe what a HCSSA must do if an individual experiences problems related to a need addressed in an IRA?

Answer: Yes. In CBA and CWP, HCSSA RNs must ensure that the service plan is appropriate, including any responsibility agreements. If HCSSA RNs determine a need is not being met as agreed, they must reassess the individual's needs and take appropriate action according to their professional judgment. This action may include consulting with the provider and individual to:

- Request authorization to revise the service plan
- Identify additional community services
- Revise or discontinue an IRA
- Convene an Interdisciplinary Team (IDT) meeting
- Request an IDT to discontinue waiver services

HCSSA RNs must review the service plan and any existing IRA in consultation with the individual at each quarterly nursing assessment required in CBA and CWP and more frequently, if necessary.

In CLASS and DBMD, at a minimum, case managers review an individual's services quarterly. If problems or concerns are discovered, case managers consult with the service provider to determine what actions are needed. If, at any time, any provider staff becomes aware of an individual experiencing any significant change in condition or circumstances, they must notify the case manager to determine the appropriate course of action. This action may include consulting with the provider and individual to:

- Request authorization to revise the service plan
- Identify additional community services
- Revise or discontinue an IRA
- Convene an IDT meeting
- Request an IDT to discontinue waiver services

Question #7: May an individual who does not have informal supports be accepted for service?

Answer: Yes. HCSSAs may accept an individual who does not have informal supports. While "lack of informal supports" is another reason some HCSSAs have cited for choosing not to serve some individuals, the term "informal supports" is not found in state (40 TAC Chapter 97) or federal (42 Code of Federal Regulations, Chapters 418 [hospice] and 484 [home health]) regulations. Informal supports are mentioned in CBA program requirements for those with an identified need for 24-hour supervision, but an IRA may still be used as described above when appropriate. IRAs are considered part of the combination of services and supports in the CBA program.

HCSSAs should refer to the guidance in Questions #1 and #4 of this letter when deciding whether to serve an individual who has no informal supports. Advocates have often stressed that it is difficult for individuals moving out of institutions to locate informal supports until they actually begin residing in the community and get the opportunity to develop a network of community supports.

Question #8: May a HCSSA staff member, a case manager, or a nursing facility staff member require an individual to assume responsibility for a need or to agree to leave a need unmet in order to qualify for services?

Answer: No. An individual must make the decision to request to have needs met through other resources or to accept responsibility for an unmet need. An individual served under the CLASS or DBMD program may request assistance from their case manager if they feel coerced. Complaints against a HCSSA employee, volunteer, or contractor; a case manager; a nursing facility staff member; or any DADS staff may also be made to the DADS Complaint Intake Unit at 1-800-458-9858.

Question #9: If an agency accepts an individual for service under an IRA and something goes wrong, will DADS regulatory surveyors cite the agency?

Answer: Licensure rules do not require HCSSAs to meet an individual's needs or ensure their safety 24 hours a day, seven days a week. Any IRA must clearly document which needs the individual will accept responsibility for or meet through other resources. **If a HCSSA employee, volunteer, or contractor sees anything of concern, they must document the situation and actions taken to help the individual address the problem.** If HCSSAs meet these requirements and an individual still suffers a negative outcome related to a need addressed in an IRA, DADS would not take enforcement action.

Question #10: Are HCSSAs often cited under 40 TAC §97.401(b) for failing to ensure that an individual's medical, nursing, and social needs can be met adequately in the individual's residence?

Answer: No. Between 9/1/04 and 3/1/07, seven citations were issued for HCSSAs violating

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40 TAC 97.401(b). Only three of those seven citations were issued since 9/1/05.

Question #11: After one HCSSA/provider agency assesses and declines to accept an individual for service, must each subsequent HCSSA/provider agency use the same assessment?

Answer: No. For an individual served in CBA or CWP, DADS staff may approve additional assessments. For an individual served in CLASS or DBMD, DADS state office program consultants may approve additional assessments. Individuals may ask DADS staff to authorize additional assessments. When a new assessment is authorized, the HCSSA/provider agency performing that assessment is not provided with copies of prior assessments.

Question #12: Is there a right to appeal the decision of a particular HCSSA not to accept an individual for service?

Answer: No. There is no process to request an appeal of the non-acceptance decision of a particular HCSSA. An individual, however, does have the right to appeal a final denial of Medicaid waiver services. When a particular HCSSA declines to serve an individual, that individual is still eligible to receive Medicaid waiver services; no denial of Medicaid waiver services has yet occurred. Meanwhile, DADS staff continue efforts to locate a HCSSA willing and able to serve the individual. If no HCSSA can be found to serve the individual, a final denial of Medicaid waiver services is provided. At that time the individual may pursue an appeal through the Texas Health and Human Services Commission Fair Hearings process. An individual who believes contract requirements have been violated due to a HCSSA declining to accept them for services may report this concern to their local case manager or to the DADS Complaint Intake Unit at 1-800-458-9858.

Question #13: What are some examples of situations where an individual might successfully establish an agreement with a HCSSA to leave a need unmet by the HCSSA?

Answer: Although particular situations vary, examples of agreements that could be established include:

- An individual who cannot transfer independently and chooses to be alone overnight with an emergency response service to use in case of emergency.
- An individual who chooses to obtain needed wound care directly from her physician instead of from HCSSA personnel.
- An individual who chooses to perform some of his personal hygiene tasks instead of having HCSSA personnel meet these needs.
- An individual who self-operates a ventilator at times to assist with breathing and does not have friends or family in the home at all times.

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Community Services Information Letter #07-06
June 20, 2007
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If you have questions about the regulatory content of this letter, please contact a HCSSA program specialist in the Policy, Rules, and Curriculum Development Unit at (512) 438-3161. For other questions, CBA and CWP providers should contact their local contract manager. CLASS and DBMD case managers should contact a CLASS/DBMD program consultant at (512) 438-3190. CLASS and DBMD direct service providers should contact a CLASS/DBMD program consultant at (512) 438-2080.

Sincerely,

[signature on file]

Barry C. Waller
Assistant Commissioner
Provider Services

[signature on file]

Gary Jessee
Assistant Commissioner
Access and Intake

[signature on file]

Veronda L. Durden
Assistant Commissioner
Regulatory Services

BCW:ss

Attachments

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Example Individual Responsibility Agreement Instructions

PURPOSE

Individual Responsibility Agreements (IRAs) do not guarantee immunity from civil or criminal liability. IRAs are intended to document agreements between applicants/consumers and their providers regarding needs for which an individual desires to take responsibility. IRAs are allowed in accordance with the Licensing Standards for Home and Community Support Services Agencies at 40 Texas Administrative Code §97.401(b).

PROCEDURE

If an IRA is used, it must be maintained as supporting documentation for the Individualized Service Plan (ISP)/Plan of Care (POC). The provider must send a copy of any IRA to the appropriate case manager.

Negotiations regarding an IRA for applicants/consumers with a legal guardian or legally authorized representative (LAR) must include the guardian or LAR. The applicant/consumer may choose to seek assistance from family or friends in negotiating the IRA, but the applicant/consumer, guardian, or LAR must sign the agreement.

The provider must not require any applicant/consumer to negotiate or sign an IRA in order to receive services. If any change to, or termination of, this agreement is proposed that would also change the ISP/POC, the provider must request authorization to revise the applicant/consumer's ISP/POC and take other actions as appropriate.

INSTRUCTIONS

Complete the form entirely; fill in each applicable blank.

1. Enter the applicant/consumer's full legal name.
2. Enter the applicant/consumer's Medicaid Number, Social Security Number, or both.
3. Provide details regarding the identified need for which the applicant/consumer agrees to take responsibility. For example: "Wound care for decubitis on right hip."
4. Describe the applicant/consumer's plan to meet this need or statements describing a preference to leave the service need unmet.
5. Describe potential consequences to the applicant/consumer if the identified need is not met.
6. Obtain signatures from both the applicant/consumer and a provider representative.

A copy of any IRA must be sent to the appropriate case manager to be included as supporting documentation for the ISP/POC.

Please note: DADS does not require the parties to use this agreement. Parties should consult with their legal representation regarding the use and limitations of this, or any, service agreement.

Example Individual Responsibility Agreement (IRA)

*This is an example service agreement between an applicant/consumer and his or her provider. It includes the elements the Texas Department of Aging and Disability Services (DADS) expects to be in a responsibility agreement. DADS does not require the parties to use this agreement. Parties should consult with their legal representation regarding the use and limitations of this, or any, responsibility agreement. **This example IRA does not guarantee immunity from civil or criminal liability.***

This Individual Responsibility Agreement (IRA) is entered _____ (provider), as into by: _____ (provider representative) and _____ (the "applicant/consumer"). The specific need described below has been identified, and the applicant/consumer has expressed a preference to take responsibility for meeting this need. The applicant/consumer understands that how this need is addressed may have significant consequences on the applicant's/consumer's health, including those listed under "Possible Consequences if the Need is Not Met."

The applicant/consumer further acknowledges that the possible consequences of not addressing this need have been fully explained and, having considered these consequences, chooses to take responsibility for the identified need. The provider and applicant/consumer agree that the applicant/consumer will take responsibility for the need. This IRA is supporting documentation for the Individualized Service Plan (ISP)/Plan of Care (POC). For each item below, attach additional pages if needed.

1. Applicant's/consumer's Name
2. Applicant's/consumer's Medicaid Number, Social Security Number, or both
3. Identified Need
4. Details of the Applicant's/consumer's Plan to Meet the Need
5. Possible Consequences if the Need is Not Met

If either party desires to change or terminate this agreement, the applicant/consumer and a provider representative must meet to discuss the cause for change or termination. If any change to or termination of this agreement is proposed that would also change the ISP/POC, the provider must request authorization to revise the applicant's/consumer's ISP/POC and take other actions as appropriate.

The applicant/consumer and provider representative have each carefully read this agreement, understand the content, and freely sign it.

Signature - Applicant/consumer or Legally Authorized Representative

Date

Signature - Provider Representative

Date

Community Living Options Information Process (CLOIP)

A. Purpose: To describe the process to be implemented by local Mental Retardation Authorities (MRAs) and the State Mental Retardation Facilities (SMRFs) related to the provision of community living options information for adult residents and/or their legally authorized representatives (LARs).

- 1) The Contract MRA will implement the community living options information process (CLOIP) for adults who reside in SMRFs.
- 2) The Contract MRA will follow DADS procedures for the implementation of the CLOIP.
- 3) The Contract MRA and SMRF will collaborate to minimize any potential conflict of interest regarding the CLOIP between a SMRF and an adult resident, an adult resident's LAR, or a local MRA.

B. Definitions: The following definitions will be used:

- 1) Contract MRA – one of thirteen (13) MRAs that have a SMRF in its local service area and with which DADS will contract for provision of the CLOIP.
- 2) Designated MRA - the MRA identified in CARE as the adult resident's county of residence MRA.
- 3) Individual – an adult resident who resides in a SMRF and who is 22 years of age or older.
- 4) Legally Authorized Representative - has the meaning assigned in the Continuity of Care Services Rule – State Mental Retardation Facilities Chapter 2, Subchapter F. A person authorized by law to act on behalf of a person with regard to a matter described in this subchapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.
- 5) Interdisciplinary Team (IDT) – has the meaning assigned in the Continuity of Care Services Rule – State Mental Retardation Facilities Chapter 2, Subchapter F. Mental retardation professionals and paraprofessionals and other concerned persons, as appropriate, who assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of whether the individual is best served in a facility or in a community setting.

- (A) Team membership always includes:
 - (i) the individual;
 - (ii) the individual's LAR, if any; and
 - (iii) persons specified by an MRA or a state MR facility, as appropriate, who are professionally qualified and/or certified or licensed with special training and experience in the diagnosis, management, needs, and treatment of individuals with mental retardation.
- (B) Other participants in IDT meetings may include:
 - (i) other concerned persons whose inclusion is requested by the individual or the LAR;
 - (ii) at the discretion of the MRA or state MR facility, persons who are directly involved in the delivery of mental retardation services to the individual; and
 - (iii) if the individual is school eligible, representatives of the appropriate school district.

C. Standardized Information Materials

- 1) Contract MRAs will provide a copy of and explain DADS "Explanation of Mental Retardation Services and Supports Publication" and "Long Term Services and Supports Form 2121" to all individuals and LARs.
- 2) In addition to the required material in the preceding paragraph, Contract MRAs will provide and explain other informational and educational materials developed and approved by DADS that provide a more complete explanation of specific types of services. Educational and informational materials will be consumer friendly and in a format that provides for easy interpretation and can include written, audio, Power Point, CD or DVD formats. The style and substance of the materials are crucial to education and awareness. Communication devices and techniques (including the use of sign language) will be utilized, as appropriate, to facilitate the involvement of the individual and LAR.
- 3) DADS will provide coordination, support and funding for these standardized materials.
- 4) DADS will assure the development of curriculum and the provision of training for Contract MRA and SMRF staff regarding CLOIP, the developed materials and their use.
- 5) Designated MRAs, upon request by the Contract MRA, will provide information about specific programs and services available where the individual or their LAR, on behalf of the individual, is interested in living. This may include, but is not limited to, specific

information about services, supports and providers in the local service area. Designated MRAs may provide the information directly to the individual and LAR or to the Contract MRA.

- 6) In addition to materials described above, individuals and/or LAR will be offered the opportunity to visit living options available in the community and to visit with individuals/peers utilizing these options with their prior consent.

D. MRA and DADS Contract Amendment Responsibilities

- 1) DADS will execute a contract amendment with 13 MRAs to implement the CLOIP beginning January 1, 2008.
- 2) DADS will provide funding to the 13 Contract MRAs based on each SMRFs adult census as a percentage of the total adult census of all SMRFs. Each Contract MRA will receive the same percentage of the total general revenue available as the percentage of the adult census of the SMRF in their local service area.
- 3) The Contract MRA will develop a budget for the CLOIP that will meet the purposes of the CLOIP and is approved by DADS.
- 4) The Contract MRA will employ staff who meet the current qualifications in 40 TAC, Chapter 2, Subchapter L for a service coordinator (SC) and in sufficient numbers to conduct the CLOIP for individuals living in the SMRF located in their service area.
- 5) The Contract MRA will meet the following performance measures associated with the Contract Amendment:
 - a) The Contract MRA will provide community living options information to all individuals living in the assigned SMRF and/or their LAR a minimum of one time per year.
 - b) The Contract MRA will complete the community living options process instrument and provide a written report of the CLOIP process to the SMRF and Designated MRA no later than 14 calendar days prior to the individual's SMRF annual planning meeting.
 - c) The Contract MRA will attend the SMRF annual planning meeting in-person or by teleconference 100% of the time unless the resident and/or their LAR has specifically requested the MRA not participate.

(Certain waivers of performance outcomes may be granted in the event the SMRF fails to provide a 45 day notice of annual planning meetings).

- 6) The Contract MRA will submit data in a format to be determined by DADS to allow for effective reporting of information about and outcomes of the CLOIP to the Legislature and other interested parties.
- 7) The Contract MRA has the flexibility to sub-contract various functions of this process to the Designated MRA under the contract amendment. However, the Contract MRA retains the responsibility for meeting budget, staff qualifications, performance measures and data requirements.
- 8) Designated MRAs remain responsible for requirements specified by the Continuity of Care Services – State Mental Retardation Facilities Chapter 2, Subchapter F and DADS Contract requirements for enrollments in Medicaid programs. Responsibilities of the Designated MRAs and Contract MRAs may be shared through written interlocal agreements.

E. MRA and SMRF Collaborative Relationship

- 1) Prior to implementation the SMRF will assist DADS staff to identify the annual planning meeting date for each adult resident of the SMRF. An annual calendar of scheduled or tentatively scheduled meetings will be provided to the contract MRA.
- 2) Post implementation of the CLOIP, the SMRF Qualified Mental Retardation Professional (QMRP) will provide the Contract MRA SC with 45-day notice of annual planning meetings.
- 3) When a planning meeting is requested at a time other than the annual meeting in which the individual or LAR needs information about community living options, all efforts will be made by the SMRF QMRP to notify the MRA SC no later than 45 days prior to the meeting date so the CLOIP can be initiated with the individual and/or LAR.
- 4) The SMRF QMRP will facilitate access by the Contract MRA SC to the individual and/or LAR for the purpose of establishing a positive relationship between them and the MRA SC.
- 5) To the extent not otherwise prohibited by state or federal confidentiality laws, the SMRF QMRP will facilitate access by the Contract MRA SC to the resident's records. The

results of the individual's most recent annual planning meeting will be copied for the Contract MRA record for preparation and use in CLOIP discussions with the individual and/or LAR. An additional copy will be provided to the individual and/or LAR by the Contract MRA SC at the beginning of the CLOIP. If the individual and/or the LAR has determined they are not interested in community options, these records would not need to be accessed.

- 6) The Contract MRA SC will provide documentation of the results of the CLOIP to the SMRF QMRP no later than 14 calendar days prior to the annual planning meeting.
- 7) The SMRF QMRP will continue to be responsible for contacting the individual and/or LAR and the Designated MRA of the date, time and location of the annual planning meeting no later than 45 days in advance.
- 8) The SMRF QMRP will continue to have responsibility for discussions with the individual and/or LAR that are needed prior to the annual planning meeting, other than the CLOIP.
- 9) The Contract MRA SC will participate in the SMRF planning meeting in addition to the individual and/or LAR. It is strongly preferred the MRA SC attend in-person but for purposes of meeting the performance measures, a teleconference will be accepted.
- 10) The Designated MRA SC may participate in the SMRF planning meeting when placement or continuity of service issues is pending.
- 11) The SMRF and the Contract MRA will work together to provide individuals and/or LARs and SMRF staff information about community living options and about the risk of moving to a community living option. This can be accomplished through organized activities or functions held at the SMRF or at the Contract MRA.

F. MRA and Adult Resident, LAR and/or Interested Family Member Collaborative Relationship

- 1) Starting January 1, 2008, the Contract MRA will utilize the annual planning meeting schedule at the SMRF to assign staff caseloads. Contract MRA SCs should be assigned in such a way as to meet with and complete the CLOIP for SMRF individuals whose planning meetings will be held March 1, 2008, and thereafter.
- 2) The Contract MRA SC will contact each individual and/or LAR on their caseload in-person or by phone, as circumstances allow, to begin to establish a positive working

relationship. An individual and/or the LAR can designate any other significant person in their life, such as some other interested family member or friend, to be involved in the discussions. The Contract MRA may develop an interlocal agreement with a Designated MRA to meet its contract obligations in this process due to the location of the LAR. This process may require several contacts in the months prior to the annual IDT staffing. If the individual or their LAR expresses they have no interest in community living options, no further contact other than annually will be made by the MRA.

- 3) The MRA SC will provide the individual and/or LAR with the standardized informational and educational materials on community living options. The MRA SC will discuss the options in a way that allows them to express an understanding and awareness of the options discussed.
- 4) If the individual and/or LAR wishes to know specific details of options and supports in a specific location, the MRA SC will make this information available and coordinate visits to community living options at their request prior to the deadline for completion of the CLOIP process.
- 5) All telephone and in-person contacts made for purposes of the CLOIP, including those by a Designated MRA, will be documented with a progress note and the appropriate encounter code provided by DADS. These will be part of the Contract MRA record along with the previous year's planning meeting results, the MRA's client identifying information record and a summary of the CLOIP as described in 6) and 7) below. The Contract MRA may include any other documents in the Contract MRA record at their discretion.
- 6) The MRA SC will document the results of the CLOIP to include the following:
 - a) the individual and/or LAR received an explanation of community living options appropriate to their level of awareness and interest;
 - b) assessment of the awareness of the individual and/or LAR of community living options. This assessment will be based on his or her experience with, information about, and exposure to community living options including visits to community options if requested; and

- c) preferences of the individual and/or LAR for remaining a resident of the state MR facility where they presently reside, for moving to another state MR facility, or for a specific community living option.
- 7) The MRA SC will document these results on the “MRA Community Living Options Information Process Worksheet.”

G. SMRF Annual IDT Staffing

- 1) The annual SMRF IDT meeting will review the MRA Community Living Options Information Worksheet and identify and document:
 - a) the awareness by the individual and/or LAR of community living options, which must be based on his or her experience with, information about, and exposure to community living options;
 - b) the preferences of the individual and/or LAR for a specific living option;
 - c) the supports and services needed by the individual in the preferred living option related to safety, mobility, medical, behavioral, psychiatric, work/day activities;
 - d) The MRA input and recommendation; and
 - e) the most appropriate living option for the individual at the current time.
- 2) Except as provided in 3) below, the SMRF IDT will develop, as part of the Personal Support Plan, an action plan to address one or more of the following:
 - a) the transition process with timelines to facilitate a timely, appropriate, and successful transition from the SMRF to the community living option;
 - b) the supports and services needed by the individual to reside in the preferred community living option at a future date;
 - c) increasing the individual’s awareness of the community living options; and
 - d) increasing the LAR’s awareness of the community living options.
- 3) An action plan or goal/objective regarding the CLOIP is not required if the individual and/or their LAR is aware of community living options and prefers that the individual remain at the current facility.
- 4) If there is not consensus by the IDT, regarding the most appropriate living option at the current time, the SMRF will implement Division 4, Section 2.276 of the Continuity of

Services Rule – State Mental Retardation Facilities, which allows for a review by the head of the SMRF and additional review by the department’s ombudsman in DADS State Office.

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MAKING INFORMED CHOICES



*Community Living Options Information
Process for Legally Authorized Representatives
of Residents in State Supported Living Centers*

Introduction

Senate Bill 27, 80th Legislature, Regular Session, 2007, changed the way in which individuals living in state supported living centers and their legally authorized representatives (LARs) will be educated and informed of community alternatives to state supported living center placement. The new law requires service coordinators from local mental retardation authorities (MRAs) to meet with each individual and their LARs, if appropriate, at least once a year before the annual planning meeting. The purpose of this meeting is to help individuals and LARs learn about services and supports available in the community. Family members and others involved in the individual's life may also find it of interest.

MRA service coordinators have experience in helping individuals successfully access options in the community. MRA service coordinators will share information about community options and will provide opportunities for state supported living center residents and their LARs, if appropriate, to make visits in the community to get a first-hand look at community options and services. This is intended to ensure individuals have comprehensive information and can make well-informed decisions on where and with whom they want to live.

This document compares two Texas Department of Aging and Disability Services (DADS) programs -- the Home and Community-Based Services Program (HCS) and the ICF-MR Program. These are the two primary community programs available to state supported living center residents who move to the community. Additional information on these programs is available on the DADS website: www.dads.state.tx.us/providers/HCS/index.cfm or www.dads.state.tx.us/providers/ICFMR/index.cfm.

The HCS program allows individuals to receive the services and supports they need—including up to 24-hour supervision—in their own homes or small (three or four individuals)



community settings. Individuals enrolling in the HCS program can receive HCS services from the HCS provider of their choice anywhere in Texas. Once enrolled, an individual may move from one provider to another or another location in Texas and the HCS services and supports will move with them. However, moving from one location to another may require the individual to choose a different provider, as not all providers offer services statewide. The community ICF-MR Program has the same basic services and rules as state supported living centers, but usually has six individuals (sometimes more) who live together with 24-hour staff support and supervision. Individuals enrolling in the community ICF-MR Program can choose to live in any ICF-MR group home in Texas that has a vacancy appropriate to meet the individual's needs. To be eligible for both the HCS and ICF-MR programs, an individual must qualify for Medicaid, have a diagnosis of mental retardation or related condition, and meet certain level-of-care requirements established by DADS.

The MRA service coordinator will contact state supported living center residents and their LARs, if appropriate, at least 45 days before the annual planning meeting. This will give individuals and their LARs adequate time to explore options. Individuals and LARs can also request the MRA service coordinator's assistance in exploring community options at any time.



HCS and ICF-MR comparison

Service	HCS	ICF-MR
Residential support 6 beds or more		√
Residential support 4 beds or fewer	√	
Foster / companion care	√	
Supervised living	√	
Supported home living	√	
Adaptive aids	√	√
Audiology	√	√
Case management	√	√
Day habilitation	√	√
Dental	√	√
Dietary / nutrition	√	√
Medical care	√	√
Minor home modifications	√	√
Nursing services	√	√
Occupational therapy	√	√
Physical therapy	√	√
Psychology	√	√
Respite	√	
Social work	√	√
Speech / hearing / language services	√	√
Supported employment	√	√

Service definitions

Residential Support: Supervision and assistance in a group home setting from service provider staff who remain awake during normal sleeping hours. Most individuals who receive residential support services do so to address medical conditions, maladaptive behaviors and assistance with activities of daily living.

Foster/Companion Care: Provided to individuals of all ages in a home-like environment as an alternative to living in a group home.



Supervised Living Services: Helps individuals who live in a group-home setting. Services include habilitation, supervision and assistance from service provider staff during normal waking hours and, if needed, during normal sleeping hours.

Supported Home Living: Helps individuals living in their own or their families' homes learn, retain, or improve daily living skills, including personal grooming and cleanliness, bed-making and household chores, preparing and eating food, and social and adaptive skills.

Adaptive Aids: Devices, controls, or appliances that enable users to retain or to increase their ability to perform daily living activities or control their environment. Adaptive aids assist with mobility, communication, or treat, rehabilitate, prevent, or compensate for conditions resulting in disability or loss of function.

Audiology: Provides a licensed audiologist to assess and direct therapeutic intervention and training, as well as to consult with individuals, their family members and service providers.





Case Management: Assisting with eligibility; coordinating and developing a service plan; monitoring the quality and delivery of waiver and non-waiver services; acting as an advocate; identifying resources and making community referrals; providing crisis intervention; and safeguarding individual rights.

Day Habilitation: Helps individuals learn, retain, and improve their self-help, socialization, and adaptive skills so they can live successfully in the community.

Dental: Emergency, preventive and therapeutic dental treatment, including routine exams.

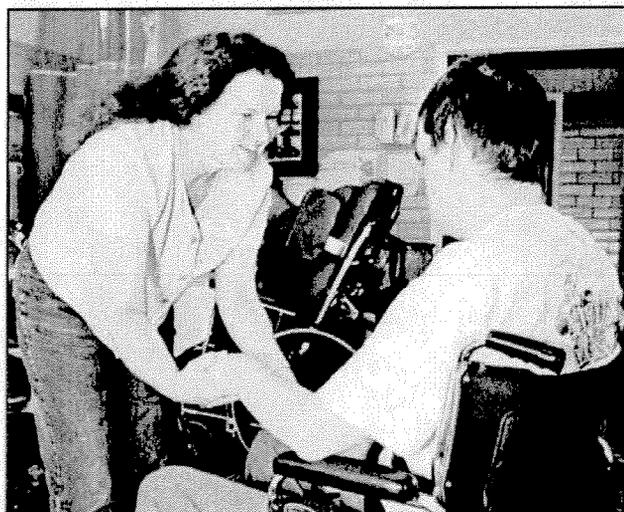
Dietary/Nutrition: Provides a licensed dietitian to conduct face-to-face assessment, consultation, and staff training. Services include determining basic or special therapeutic nutritional needs.

Minor Home Modifications: Assess the need for, arrange for, and modify or improve living quarters to allow community living and ensure safety, security, and accessibility.

Medical Services: Services provided by a licensed physician.

Nursing Services: Services provided by a licensed nurse include monitoring health conditions, administering and monitoring medication, providing referrals for medical services, and training individuals, their family members, and support personnel.

Occupational Therapy: Skilled treatment to help individuals achieve independent functioning in all



making informed choices

aspects of their lives. Services include assessing needs, developing a treatment plan, determining therapeutic intervention, training, helping with adaptive aids, and consulting with the family and provider.



Physical Therapy: Helps individuals improve their range of motion and physical functioning, as well as retain their physical conditioning. Services include assessing needs, developing a treatment plan, determining therapeutic intervention, training, helping with adaptive aids, and consulting with the family and provider.

Psychology: A licensed psychologist performs services that modify and improve cognitive and affective skills. Services include counseling individuals and assessing and training direct service providers or family members with regard to a specific treatment plan.

Respite Care: This service provides temporary relief for unpaid primary caregivers or provides care when the caregiver is absent. Respite services are provided either in or out of the home.

Social Work: Assessing needs, providing direct therapeutic intervention and training and consulting

Speech/Hearing and Language Services: Corrective or rehabilitative treatment for individuals with speech, hearing or language disorders. Services include assessing needs, developing a treatment plan, determining therapeutic intervention, training, helping with adaptive aids, and consulting with the family and provider.

Supported Employment: Helps to sustain paid employment for individuals who, because of their disability, require intensive, ongoing support to perform in a work setting. Supported employment must be provided at work sites in which individuals without disabilities are also employed. Services include adaptations, supervision and training, as related to the individual's diagnosis.



DADS is grateful to Imagine Enterprises for allowing us to use *Which Waiver Does What? An Unofficial Quick Reference Guide to the Texas Medicaid Waivers* as a template for this document. The quick reference guide can be found at www.imagineenterprises.com.



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