

Developmental Services Case Management Manual

August 15, 2008

Case Management Manual

Mission Statement

Developmental Services will provide leadership and be an active partner in Maine's comprehensive system of support to individuals whom we serve. At the foundation of this system is the belief that all individuals, through self-determination, can achieve a quality of life consistent with the community in which they live. Supports will be flexible and designed in a manner that recognizes people's changing needs throughout their lifetimes.

I. Introduction

Role of Case Management:

The role of the case manager involves working with the participant and others who are identified by the participant, such as family members, in developing an individualized support plan, and assisting the person to implement that plan. The case manager's primary customer is the person with disabilities and their family. Case managers will work closely with the participant to assure his or her ongoing satisfaction with the process and outcomes of the supports, services and available resources. The primary role of the case manager is to assist in identifying and implementing support strategies that reflect the participant's personal vision for a desired life

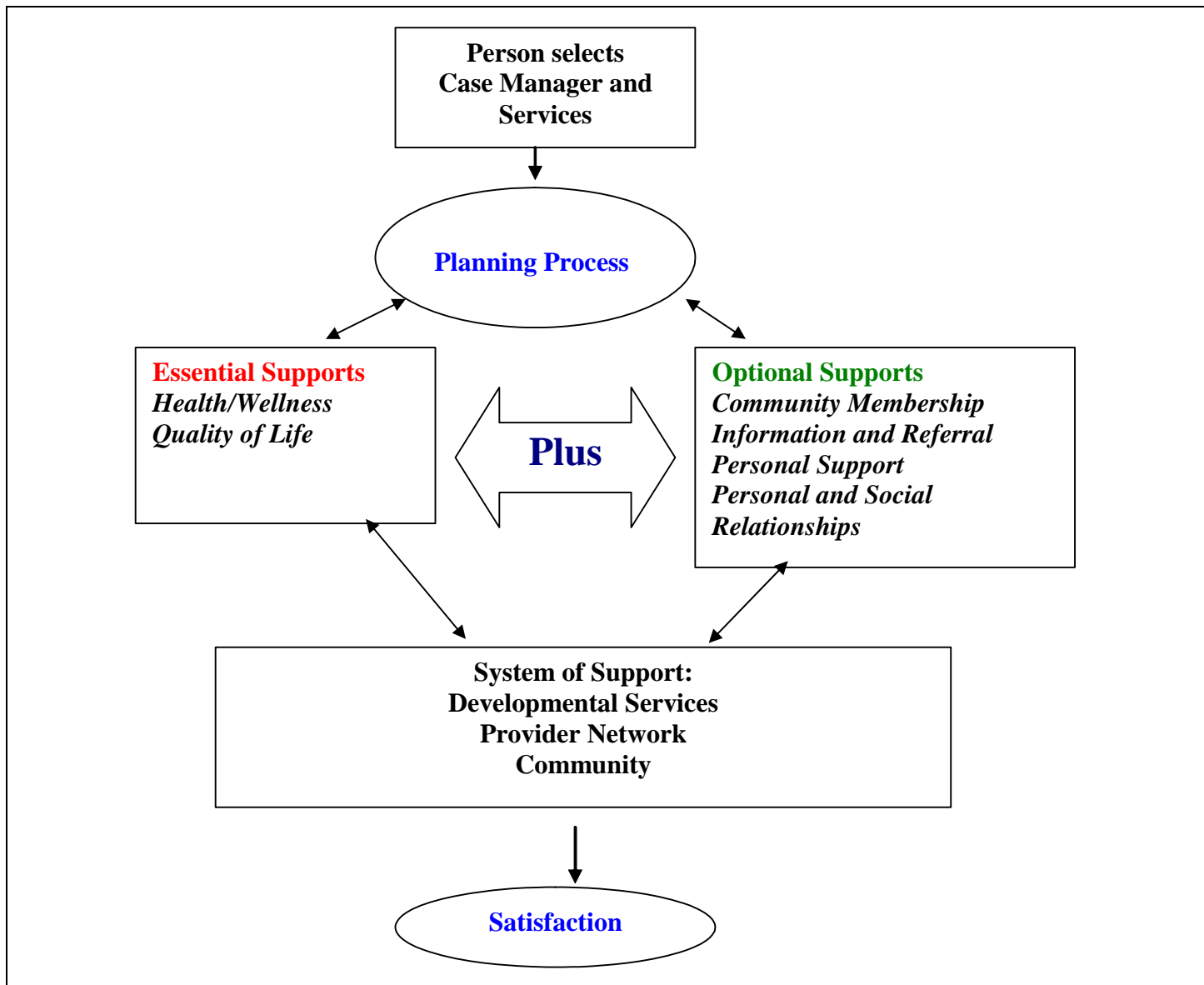
There are also several roles and responsibilities that the case manager needs to balance while providing this primarily role:

- Relationship with family- it is clear that for many individuals the role of family in their lives is very important. The case manager needs to take the lead whenever appropriate from the person with disabilities regarding the involvement of family members; ; however it is the intention of this service to include family in the circle of support whenever it is possible and desired by the person.
- Relationship with Developmental Services – the case manager should see themselves as the main connection for the person to Developmental Services. A great deal of support will be available through access to information systems, resources, training and education, and quality assurance to assure that the case worker has access in the state system. With that come responsibilities in regards to professional conduct and working partnership and relationship between the various systems and case management. It is clear this is in the best interest of the people receiving this service.
- Relationship with other providers- It is imperative that the case manager strives to maintain quality relationships with community supports and community providers. This will facilitate access to services for the people they represent. If conflicts or dissatisfaction occurs for the consumer with other community supports or providers it is the role of the Case manager to assist the consumer and family to work through those problems.
- Relationship with community- you will see in the description of this service a very heavy emphasis on community. There is a strong belief that it is vital that people providing case management know the local community and the possibilities that exist for people. Thus, maintaining a positive professional relationship with members of the local community

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and working to access opportunities for people with disabilities is an essential part of this work.

These Case Management Standards have been developed by Developmental Services to provide guidance to people with disabilities, families, state departments, community providers, and case managers providing case management services to adults.



Case Management: Defining the Service

Using a person-centered planning process, the case manager will work with the participant, and others identified by the participant, in the development of an individualized support plan which will reflect the participant's personal vision for a desired life. The case manager will assist the participant, and others, in identifying support strategies that can be implemented to guide the participant to reach (attain) self-identified goals and wishes. Support strategies must incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. The case manager will work closely with the participant to assure his/her ongoing satisfaction with the process by making sure that the activities selected always reflect the supports and services desired, and needed, by the participant. In addition, the case manager will analyze the outcomes of the supports and services implemented, and will monitor available resources to support the participant's plan. Strategies and implementation plans must be comprehensive and address the following: health and safety of the participant; housing and employment; social networking; scheduling and documentation of appointments and meetings, including on-going person-centered planning; utilization of natural and community supports; and the quality of the various supports and services utilized by the participant.

Case Management Service Delivery Model.

This model identifies various components associated with support coordination. It identifies services as **Essential** and **Optional**. This model allows persons who are eligible for services to fashion support coordination in a manner that maximizes the participant's control by creating a flexible service menu therefore fashioning support coordination in a manner that focuses effort towards the individual's personal vision for his/her life.

Essential services are not intended to be intrusive. Rather the services are tailored to focus on the health and wellness of all participants and to offer assistance, guidance and support around skill development designed to help keep the participants safe from harm and exploitation.

Optional services are designed to promote the participant's priorities and thus be a reflection of the participant's future planning process.

Essential Services:

Health and Wellness:

Health and Wellness involves activities designed to promote, support and maintain the participant's overall health. When necessary and indicated *, activities may include:

- Coordination and arrangement of medical and dental appointments and treatments
- Coordination and arrangement of mental health treatment and services
- Coordination and arrangement for nutritional/fitness support
- Coordination and arrangement for any therapies needed (i.e.PT, OT, speech, etc)
- Assistance in acquiring and usage of any needed medical equipment
- Assistance with the management of chronic illnesses and condition
- Assistance with grief counseling as needed

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- Necessary and indicated refers to activities identified and documented as such in the person-centered planning process, and with which the participant will require assistance in order to achieve. Ex. A person with diabetes who is not able to independently coordinate and arrange for needed medical care, and requires additional supports to maintain health.

Quality of Life:

Quality of Life is a category of service that balances freedom of choice and individual lifestyle, with personal responsibility and system accountability. The focus should always be on promoting the participant's personal competencies that would result in safety and freedom from abuse, neglect and exploitation. Such activities could include:

- Assist, coordinate and secure information on services and options that are available so that decisions are informed choices
- Offer assistance and coordination obtaining legal resources such as partial or full guardianship
- Assist in the coordination and/or mediation of problem resolutions that may arise with housing, employment, community membership and day support services
- Coordinate services, or engage directly with the participant, to avoid or resolve a crisis, or any other challenging personal situation.
- Assist, coordinate or complete any required reporting obligation

Optional Services:

Community Membership:

Community Membership is a group of services designed to assist the participant in understanding and accessing the neighborhood and community in which one lives. In essence, the purpose of Community Membership services is to locate, and connect the participant, to sources of personal support in their community that enhance the participant's vision for a desired life. Services may include:

- Assist, coordinate or introduce the participant to community groups, agencies and organizations that reflect the participant's personal interest and vision for a desired life (churches, Weight Watchers, hiking clubs as examples)
- Assist, coordinate or arrange opportunities for the participant to volunteer in activities that reflect the participant's personal interest
- Assist, coordinate or provide information and training on local resources and how to use those resources
- Assist, coordinate or locate support groups that may reflect the participant's interest
- Assist, coordinate or arrange for cooperatives or similar self-help activities

Individual Support Team (IST)

Statement of Purpose:

Persons with Mental Retardation who receive services from the Department of Health and Human Services (DHHS) may, from time to time, experience crisis situations. When a crisis occurs, the support

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of an Individual Support Team (IST) is often invaluable. An Individual Support Team consists of members of the person's planning team and other professionals, family, or friends that the planning team determines would be supportive to the person in a time of crisis. The IST is developed by the planning team and operates under the planning team's direction. The role of the IST is to support the person and provide services designed (1) to prevent crisis situations or (2) provide support during a crisis.

Development of the IST

1. Criteria: An IST will be developed whenever the person receiving services experiences any of the following incidents:
 - a. Admission into a state run crisis residential program or other respite home as a result of a crisis situation.
 - b. Admission to an inpatient psychiatric hospital.
 - c. Three restraints in a two week period
 - d. Becomes homeless. A person will be considered homeless when he/she cannot return to his/her present home, and does not have a support network or a plan in place for future timely residential services.

Other. "Other means that, upon review of a situation or a series of situations, a person's team recommends creation of an IST. Examples might include behavior or psychiatric concerns that do not meet criteria above, health concerns of the consumer or family members, etc.
2. When one or more of the above criteria occur for an individual the Individual Support Coordinator (ISC) will be notified and will coordinate the convening of the person's planning team within seven working days.
3. If the individual has been admitted to a state run crisis residence an assessment will be done at the crisis home. This assessment will include a review of the incident, observations made in the home, environment of the crisis location, and recommendations for future intervention and support.
4. The person's planning team will review the crisis incident and any documentation provided, such as hospital assessments, restraint information, resource development information. The planning team will then develop a written crisis intervention plan, and will identify IST members and their roles. This plan should be preventative in nature and should include guidance about future response to potential crisis situations.
5. The person's planning team will review the need for specific training and identify who is responsible with clear time frames.
6. The IST will report to the person's planning team at least annually, but can determine if more frequent review is needed. The I.S.T. will determine what type of communication and review process is necessary for its role. The planning team also will determine if and when the I.S.T. has completed its work and may be dissolved.
7. A member of the Crisis Team and the person's I.S.C. must be a part of the I.S.T. Whoever is designated, as the lead coordinator for the planning process will monitor the I.S.T. team. The Crisis Team will maintain 24 hour, ten day, and quarterly follow-up to individuals who have an active IST. It will provide written follow-up to the I.S.C. for distribution to the planning team as appropriate.

Information and Referral:

Information and Referral is a group of services designed to ensure that the participant has access to information. When necessary and indicated*Services may include:

- Obtaining information and assisting, coordinating or making referrals to federal programs such as SSI and housing programs
- Obtaining information, and assisting the participant in obtaining benefits from the state to which they are entitled, i.e. MaineCare (formerly Medicaid), Medicare, prescription drug programs, welfare, vocational supports, educational supports as examples
- Obtaining information, and assisting or coordinating in the making of referrals for medical and or mental health services
- Obtaining information, and assisting or coordinating in the making of referrals for membership in local support or self-help groups
- Obtaining information, and assisting in the participant's ability to understand the support system including their rights, responsibilities, grievance options and the decision-making process

Personal Support and Coordination

Personal Support and Coordination is a group of services designed to offer assistance and supports to promote the participant's articulation of a personal vision for a desired life in the community. When necessary and indicated*, services in this category may include:

- Assist, coordinate or facilitate the participant's future planning process
- Assist in coordination of opportunities for the participant to attend preferred community activities;
- Assist in the coordination of opportunities for the participant to attend those activities with people who are friends and allies rather than agency staff;
- Assist in the coordination of options that offer a greater variety of activities in which the participant can become engaged;
- Assist in the coordination of opportunities for the participant to engage in more activities with friends and allies and without paid staff
- Assist in the coordination of the expanding the network of the participant's social relations to include more individuals who are not agency staff.

Personal and Social Relationships

Personal and Social Relations is a group of services designed to connect the participant to sources of personal support in the community. When necessary and indicated*Services and supports may include:

- Assist in, coordinate or arrange the provision of instruction, guidance, modeling and mentoring
- Assist in the coordination, or facilitate referrals for adult education, memberships in community groups, agencies or organizations and or volunteering with community projects
- Assist in the coordination or provision of physical and or other support that may be necessary to participant in community events
- Assist in the coordination and arranging of one to one relationship building, with a decided preference for natural supports from family, friends, neighbors and allies,

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- Assist in the coordination and arranging of modeling, mentoring and support from people associated with other generic community and civic organizations
 - Assist, coordinate, facilitate, desired outcomes such as connections to sources of support through families, friends, allies or people associated with community or civic organization
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Definitions;

“**AAG**” means an Assistant Attorney General.

"**Abuse**" means the willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm or pain or mental anguish; sexual abuse or exploitation; or the willful deprivation of essential needs.

"**Advocate**" means an employee of the Office of Advocacy.

"**At Risk**" means a situation in which there is reasonable cause to believe that injury, hazard, damage, or loss can occur.

“**Assistant Attorney General**” means a representative of the Department of Attorney General, the Department’s legal counsel.

“**Autism**” means a developmental disorder characterized by a lack of responsiveness to other people, gross impairment in communicative skills and unusual responses to various aspects of the environment, all usually developing within the first 30 months of age (34B MRSA §6002).

“**Capacity**” means possessing sufficient understanding or capacity to make or communicate responsible decisions concerning one’s own person. Sometimes referred to as “competence”.

"**Caregiver**" means an individual who has or who assumes responsibility for the care of an adult. Caregivers include primary support staff.

”**Case Management Standards**” means a collection of criteria describing the level of excellence in performance expected of Case Managers.

"**Case Manager**" (CM) means the staff member of Developmental Services with the responsibility for coordinating a persons planning process and services.

"**Person**" “**Client**”, or "**Consumer**" means a person applying for or receiving Developmental Services supports and /or services, or the person for whom those services are requested.

"**Commissioner**" means the Commissioner of the Department of Health and Human Services.
“Competence.” See “Capacity,” “Incapacitated Person.”

“**Consent for Treatment, Payment and Operations**” means the form, located at <http://www.maine.gov/dhhs/bh/HIPAA/PrivacyNotice/ConsentTreatment.html>

"**Conservatorship**" means a fiduciary relationship created by court appointment of a conservator to manage the financial affairs of a protected person, based upon a finding of inability of the protected

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person to effectively manage his property and affairs, pursuant to 18-A MRSA §5-401 et seq. and 18-A MRSA §5-601 et seq.

"Consultant" means an individual, agency, firm, or organization that is independent of the Department of Behavioral and Developmental Services.

"Consumer" or **"Person"** means a person applying for or receiving Developmental Services supports and /or services, or the person for whom those services are requested.

"Consumer Advisory Board" means the body established by CAB v. Glover, et al., Civil Docket No. 91-321-P-C.

"Correspondent" means an individual designated as next friend of a person according to the following order of preference and principles:

- In the first instance, the person's private guardian;
- If the person does not have a guardian or has a public guardian, the person's parents or parent; If the parents are deceased or their whereabouts cannot, with due diligence, be ascertained, they have failed to designate an appropriate representative, the relative, if any in closest relationship with the person who has, at least once within the previous year, manifested interest in the person by communicating with Developmental Services regarding the person; or
- If no correspondent can be designated according to section a, b, or c above, or if the legal guardian, parent, or relative is unable to exercise his/her rights hereunder because of age, illness, distance, or some other compelling reason, the correspondent shall be an individual designated by the Consumer Advisory Board.

A person with mental retardation who is not under guardianship may decline a correspondent.

"Crisis" means any incident, behavior, activity, or pattern of activity, which could lead to the loss of a person's residence, program, or employment. A crisis may also be an incident that results in undue mental or emotional stress or trauma.

"Deaf" means a condition in which a person's sense of hearing is non functional for the purpose of spoken communication with or without hearing aids. Communication must occur through visual and/or tactile means.

"DHHS" means Department of Health and Human Services.

"EIS" means the Enterprise Information System, a data management information system of the Department.

"Emergency" an unforeseen event or condition requiring prompt action. Emergencies include situations in which:

1. An incapacitated adult is in immediate risk of serious harm; and is eligible for Developmental Services.
2. The incapacitated adult is unable to consent to services which will eliminate or diminish the risk; and is eligible for Developmental Services.
3. There is no guardian to consent to emergency services.

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"**Emergency Services**" mean those services necessary to avoid serious harm.

"**Exploitation**" means the illegal or improper use of a mentally retarded incapacitated adult or his/her resources for another individual's profit or advantage.

"**Guardian**" means a person(s) or agency with ongoing legal responsibility for ensuring the care of an individual, appointed pursuant to 18-A MRSA 5-301 et seq and 5-601 et seq.

"**Guardianship**" means a legal relationship by virtue of which a guardian is given authority to make decisions regarding the person of a ward. The guardian of an individual who is incapacitated by reason of mental retardation may be appointed by will or by a court pursuant to 18-A MRSA 5-301 et seq and 5-601 et seq.

"**HIPAA**" means Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191).

"**HIV**" means Human Immunodeficiency Virus.

"**Incapacitated person**" means any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause except minority to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person (18A MRSA §5-101, 34B MRSA §5001(2)).

"**Case Manager**" (CM) means the staff member of, or contracted by Developmental Services with the responsibility for coordinating a person's planning process and services.

"**Intake**" means the process by which a consumer and Developmental Services establish a formal relationship.

"**Intake status**" means the period during which a person who has been referred for services is assessed to determine eligibility.

"**Intake worker**" means the DHHS Staff member assigned responsibility for completion of the intake process.

"**Developmental Services**" means Developmental Services of the Department of Health and Human Services.

"**MRSA**" means Maine Revised Statutes Annotated.

"**PASRR**" means Preadmission Screening and Resident Review, a program to ensure that persons who are otherwise eligible for care in a nursing facility (NF) and who also have a mental illness or mental retardation receive the additional care necessary to meet their needs.

"**PCP**" means a person centered planning process.

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“**PDD**” means pervasive developmental disorder.

”**Permission for Services form**” means the form that establishes the basis for an ongoing relationship between an applicant and Developmental Services.

”**Person Centered Planning**” (PCP) means a process in which the needs and desires of the person are articulated and identified and an action plan is created to address those needs and desires.

”**Placement**” or ”**Residence**” means a residence in the community in a group home, foster care home, natural or family home, apartment or house, boarding home, or similar residential facility coupled with a program element or work situation which meets the person's individual needs or desires.

”**Primary Support Staff**” means the individual who have or who assume responsibility for the care of an adult, caregivers.

”**Psychosocial evaluation**” means a comprehensive inventory and evaluation of a person’s life history, skills and needs. It usually includes, to the extent that information is available:

- family makeup, involvement and other natural supports;
- parental status;
- spiritual practices;
- sexuality;
- educational background and needs;
- employment history and needs;
- medical, dental, psychiatric and substance abuse history, including history of trauma, and any needs for services;
- legal involvement and needs;
- financial status and needs;
- housing status and needs;
- other support needs, including recreation, transportation, communication.

”**Public Guardian**” means Developmental Services or the Department of Health and Human Services when appointed as such by a court pursuant to 18-A MRSA 5-601 et seq.

”**Residence**” or ”**Placement**” means a residence in the community in a group home, foster care home, natural or family home, apartment or house, boarding home, or similar residential facility coupled with a program element or work situation which meets the person's individual needs or desires.

”**Ward**” means a person for whom a guardian has been appointed.

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Section I Case Management Standards & Mission Statement

Case Management Standards

Developmental Services adheres to a set of Case Management Standards that are very closely based upon the National Association of Social Workers (NASW) Standards approved by the NASW Board of Directors in June of 1992. The interested reader is referred to <http://www.naswdc.org>.

Following is a presentation of the 10 standards. In some cases the standards have been modified slightly to be best apply to the consumers we serve. Along with each standard is a brief discussion and a list of some of the relevant policies and procedures to be found in this manual.

Standard 1. The Case Manager shall meet the standard set forth in the job description of a Case Manager with the Department of Health and Human Services (DHHS) or the standards set forth in the certification for Community Case Management.

Standard 2. The Case Manager shall use his or her professional skills and competence to serve the consumer, whose interests are of primary concern.

Case Managers have two sorts of ethical obligations. The first is to resolve all scheduling and procedural conflicts by giving preeminent consideration to the concerns of consumers and their families. While the convenience of a Case Manager is a legitimate concern, during the workday it is secondary to the convenience of the consumer. The second obligation is to be sensitive to the possibility that the Department or Agency may make a policy decision for its own convenience rather than for the direct interest of consumers. If a Case Manager strongly feels that the Department or Agency is doing so, then the Case Manager has an obligation to raise the issue, first to the immediate supervisor; if this action does not provide resolution, the issue must be raised to successive levels of supervision and to the Office of Advocacy. As professionals, Case Managers are obligated to hold both themselves and the Department to the highest possible ethical standards.

- Consumer/Case Manager Relationship
- Client Rights
- The Rights of Maine Citizens with Mental Retardation

Standard 3. The Case Manager shall ensure that consumers are involved in all phases of case management practice to the greatest extent possible.

The primary vehicle for assuring that consumers achieve this autonomy is the Person Centered Plan. However, some consumers elect not to have a Plan, and the Case Manager has the same obligations in these cases.

- Personal Planning Process/Protocol PCP
- Mission Statement

Standard 4. The Case Manager shall ensure the consumer's right to privacy and ensure appropriate confidentiality when information about the consumer is released to others. Case Managers are reminded that even in cases where a particular consumer appears to be unconcerned or uninterested in issues of privacy and confidentiality, Case Managers are still obligated to adhere to a high standard.

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- Release of information
- HIPAA (<http://www.maine.gov/dhhs/bh/HIPAA/Index.html>)

Standard 5. The Case Manager shall intervene at the consumer level to provide and/or coordinate the delivery of direct services to consumers and their families.

Developmental Services in the State of Maine are highly integrated with community resources. For this reason, the particular shape of case management services will differ greatly from one consumer to the next. In some instances, the Case Manager may be virtually the only liaison for the consumer and her family, while in other cases, a consumer may be receiving a wide variety of services and supports from a network of community providers. Accordingly the Case Manager may be operating as a direct Social Worker in one case, as a service coordinator in another, and as a quality assurance monitor in another. In all likelihood, a given Case Manager will have the whole spectrum of types of cases, and will need to develop skills in a variety of areas. Standard 5 speaks primarily to the direct service category, while Standards 6 and 8 address coordination and quality assurance. In addition to possessing good interpersonal and communication skills, a Case Manager needs to develop, through education or experience, an understanding of interpersonal and family dynamics and a good background in the nature and needs of various disabilities. This is particularly true since many of the consumers whom we serve have secondary diagnoses related to mental health, substance abuse, or physical disabilities. Further, some consumers have children, with whom they may need assistance. Others may be involved in difficult family situations. This manual cannot comprehensively identify all the areas in which a Case Manager may be called upon to act, but it is nonetheless an expectation of the Department that Case Managers will strive to expand their skill base across this entire spectrum of topics.

- Eligibility
- Referral and Intake
- Personal Planning Process
- Residential
- Mental Retardation Policies

Standard 6. The Case Manager shall intervene at the service systems level to support existing case management services and to expand the supply of and improve access to needed services.

Case Managers are expected to become progressively more knowledgeable about resources available to consumers throughout their service areas. These resources include residential agencies and providers, respite providers, vocational services, professional and therapeutic services, and the full range of community resources as available to consumers as they are to all other community members. It is expected that Case Managers will take every opportunity to share any information that they gather with all of their colleagues, in order to strengthen the service coordination and delivery system for the system as a whole.

- Medical Services
- Ancillary Services

Standard 7. The Case Manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible in carrying out all case management functions and activities.

- Family Support Program

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- Financial Procedures
- Case Management Billing
- Waiver and ICF/MR Classification Requirements

Standard 8. The Case Manager shall participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates as well as the case manager's own case management services, and to otherwise ensure full professional accountability.

- Quality Improvement Activities
- Grievance and Appeal
- Developmental Services Quality Improvement Plan

Standard 9. The Case Manager shall carry a reasonable caseload that allows him to effectively plan, provide, and evaluate case management tasks related to consumer and system interventions.

- Caseload Ratio
- Co-Case Management

Standard 10. The Case Manager shall treat colleagues with courtesy and respect, and strive to enhance interprofessional, intraprofessional, and interagency cooperation on behalf of the consumer.

Section II Eligibility for Developmental Services

Eligibility for Developmental Services

3.1 POLICY STATEMENT ON MENTAL RETARDATION

As part of its process for the provision of services to persons with mental retardation, the Office utilizes the definition of mental retardation as adopted by the American Association on Mental Retardation and the American Psychiatric Association.

"Mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period". (34-B MRSA §5001(3)).

1. Sub-average intellectual functioning is defined as an intelligence quotient obtained by assessment with one or more of the individually administered general intelligence tests, e.g. Wechsler Scales, Stanford-Binet, Cattell or comparable tests. Individuals obtaining a score more than two standard deviations below the mean (average) score (approximate I.Q. score of 70) will be assessed as having subnormal intelligence, e.g., Wechsler approximately 69, Stanford-Binet, approximately 67.
2. Adaptive behavior is defined as the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. Level of adaptive behavior will be appropriately determined through the use of developmental scales, such as the AAMD Adaptive Behavior Scales, Vineland Social Maturity Scale, Fairview Developmental Scale, Callier-Azusa Scale, the Alpern Bolls Assessment Scale, etc. Other scales may be used, but must have appropriate standardization and norms to effectively assess adaptive behavior. Individuals having scored more than two standard deviations below the mean for normal age peers, or otherwise falling within a similar normative classification of "Developmental Retardation" (depending on instrument used), shall be determined to have deficits significant enough to be considered as potentially having mental retardation.
3. Developmental period is defined as age eighteen (18) years or younger.

Once an applicant has been determined ineligible for services, reapplications shall only be considered if there is new information concerning the applicant's functioning during the developmental period.

3.2. Policy Statement on Pervasive Developmental Disorders

The Office uses the definition of autism codified in 34-B MRSA §6002. Autism refers to a developmental disorder characterized by a lack of responsiveness to other people, gross impairment in communicative skills and unusual responses to various aspects of the environment, all usually developing within the first 30 months of age. In addition, for purposes of this rule, an adult person with autism is one:

1. Whose diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association) is within the category of Pervasive Developmental Disorders, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, or Pervasive Developmental Disorder, Not Otherwise Specified; and manifested during the developmental period, (Developmental period is defined as age eighteen (18) years or younger).and
2. Who has been assessed as having an adaptive behavior score at least two standard deviations below the mean as measured by an adaptive behavior scale as described below. The office will require an adaptive behavioral scale test that has been completed within two years of the date of eligibility determination and reserves the right to request further testing.

3.2.1. **Assessment Tools.** Only the following assessment tools shall be used to determine a person's adaptive behavior score: Adaptive Behavior Assessment System (2d ed., known as ABAS-II), the Vineland Adaptive Behavior Scales (2d ed., known as Vineland-II), or other substantially similar assessment tool as approved by the Office. Adaptive behavior shall be assessed using one of these tools in the context of a clinical interview where, as deemed clinically necessary, the examiner is able to evaluate responses from one or more participants in the testing environment. Testing must occur in the least restrictive setting available.

3.2.2. **Assessment Process.** The intake process described in 34-B MRSA §5467 shall be followed. In addition, as part of the assessment process, the office will establish an advisory committee whose members shall be appointed by the Office Director as follows:

1. One member who is a employee of the Office of Adults with Cognitive and Physical Disabilities who shall act as the committee chair;
2. One member who is not an employee of the Department and is a psychologist who has a working background in the testing and treatment of Pervasive Developmental Disorders, is licensed to practice in Maine and meets the requirements to perform a comprehensive evaluation as set out in 34-B MRSA §5468; and
3. One member who is not an employee or provider with the department for any other service, is a professional with knowledge of clinical evaluation standards, testing protocols and eligibility criteria and has a working background in the testing and treatment of Pervasive Developmental Disorders.

When requested by the office, this committee shall render an opinion, at any time, on an application for eligibility by reviewing the complete record, including the intake record, and all evaluation and test results. The committee may request additional information or

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testing. The committee may provide opinions or concerns regarding the tests and evaluations reviewed. The committee shall provide its opinions in a written report to the office.

3.3 APPEAL PROCESS

It is the policy of the Office to ensure that needed services are provided to persons with mental retardation and/or autism in accordance with the laws of the State of Maine to the extent resources permit.

Further, it is the policy of the Office to provide for review of a decision in which a person is found ineligible for services from the Office.

Whenever the regional office of the Office determines that an applicant is not eligible to receive services, the applicant, the applicant's legal guardian, or anyone acting on his/her behalf, shall be advised by the regional office, in writing, of such a determination and of his/her right to appeal that decision and of the availability of an advocate to assist, if the applicant so desires, in pursuing a review of the determination. In the absence of anyone acting on behalf of the applicant, the applicant shall be notified, both verbally and in writing, of the ineligibility determination and the Office of Advocacy shall be notified.

OFFICE DIRECTOR REVIEW

The applicant, the applicant's legal guardian or anyone acting on behalf of the applicant, may request a review of the decision. The request for review shall be in writing and be submitted to the director of the Office. The written request shall be submitted within sixty (60) calendar days of the date of receipt of the written determination from the regional office. In the absence of anyone acting on behalf of the applicant, the applicant shall be notified, both verbally and in writing, and the sixty (60) day timeframe shall begin to run on the date when both forms of notification have been completed.

Upon receipt by the Director, and within twenty-one (21) working days of receipt of the written request for review, the Director, or his/her designee, shall schedule a meeting. The meeting shall include the applicant, his/her representative and the appropriate regional staff of the Department.

The Director or designee shall hear and give consideration to all relevant information presented at this meeting and render a decision within twenty-one (21) calendar days of the date of the meeting.

This meeting shall be electronically recorded. The Director's decision shall be in writing, sent to all parties present at the meeting, and shall contain the following:

1. a statement of the issue,
2. relevant facts brought out at the meeting,
3. pertinent provision of law related to the decision,
4. the decision and the reason for the decision,
5. the procedure to request an appeal.

Commissioner Review

The applicant or anyone acting on his/her behalf may request that the Commissioner review the Office Director's decision. A request for this review shall be submitted in writing within fifteen (15) working days of the date of receipt of the Office Director's decision. The request shall be submitted to the Commissioner who shall arrange, within twenty-one (21) calendar days of receipt of the request, for a meeting to be conducted by the Commissioner's designee.

The meeting shall include the applicant, his/her representative and the appropriate regional staff of the department.

The Commissioner or designee shall review the decision made by the Director. The Commissioner shall hear and give consideration to any relevant information presented at the hearing and render a decision within twenty-one (21) calendar days of the date of the meeting.

The meeting shall be electronically recorded. The Commissioner's decision shall be in writing, sent to all parties present at the meeting, and shall contain the following:

1. a statement of the issue,
2. relevant facts brought out at the meeting,
3. pertinent provision of law related to the decision,
4. the decision and the reason for the decision,
5. the right of the applicant to appeal this final agency action

Further review may be sought through the procedures as set forth in the Maine Administrative Procedure Act, Chapter 375, sub-chapter VII (5 MRSA, Section 11001, *at seq.*). This statute provides for further appeal.

Referral and Intake

I. Introduction

Intake is a process by which a person with mental retardation/autism/or pervasive developmental disorder and Developmental Services establish a formal relationship.

People referred to the Department are considered to be in intake status until eligibility is determined. Eligibility is defined in the Developmental Services policy entitled Eligibility for Developmental Services. (34B MRSA Section 5465) People are eligible for Developmental Services for adults at the age of 18.

Foreign language and/or sign language interpreters must be utilized whenever there is a communication barrier to comply with Federal and State Laws concerning equal access to service.

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II. Referral

- A. The referral/intake process begins when a request for Developmental Services is made by a person with mental retardation/autism or PDD or by any person or agency acting on behalf of the person who is not currently or has not in the past received services from Developmental Services. The consumer and/or guardian must consent to the referral unless it is an Adult Protective Referral. This consent can be given by the person or guardian over the phone. Persons acting on behalf of the individual must provide a sign release prior to information being accepted by DHHS.
- B. Each regional office has established a procedure whereby a referral can be accepted at any time so that a person making a referral is not required to re-contact the regional office. The staff person accepting the initial referral is responsible for completing the referral information used by a regional office. While completing this form, the staff person should attempt to determine the applicant's circumstances and need for services, how the applicant may be contacted, the possible need for emergency intervention, as well as the identifying information indicated on the form. The staff person accepting the referral should be sufficiently aware of Developmental Services to answer general questions regarding services.

III. Intake

- A. The referral information is forwarded to the regional supervisor who assigns responsibility for completion of the intake process to the appropriate staff person. This person will be referred to as the intake worker. Eligibility may be determined at any point during the referral/intake process once enough information is available to ascertain the eligibility of the individual.
- B. The intake worker assigned will proceed promptly with all prescribed intake activities. The initial contact will take place within 10 working days of the initial referral. For Adult Protective referrals, action should be taken as soon as possible. Specific actions to be taken in this situation are outlined in the cooperative agreement between Developmental Services and Adult Protective Services. Copies of this are available in each regional office.

The intake worker shall contact the applicant, or other informant, in order to obtain Permission for Service. The Permission for Service form establishes the basis for an ongoing relationship between the applicant and Developmental Services. The form permits Developmental Services to act on behalf of the person with mental retardation.

The competent adult with mental retardation/ autism/PDD should sign the permission for himself or herself. The term "competence" used here implies the ability of the person to understand the nature of the services to be provided, and the appropriateness of such services for himself or herself. In some cases, incompetence may have already been determined by the court and therefore, the person will have a court appointed guardian. The working assumption is that if legal incompetence has not been established by the court the applicant is, therefore, competent. Competence may later be clarified by court action. A competent person with mental retardation or his legal guardian may decline Developmental Services.

The date of the signed permission shall be considered the date that the intake process has begun. At this time the intake worker will determine whether a visit is necessary at this time

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or at a later date. If the individual is already receiving case management from Children's Services, as an example, it may not be necessary to do a visit if all relevant information is available for intake.

- C. If available information from the source of referral indicates that pre-arrangement of the visit is not advisable, this fact should be noted and documented. The goals of a visit are: the functional assessment of the applicant, the compilation of historical and biographical information regarding the applicant, and the completion of various forms related to the intake.

The selection of the site of the visit should be in an environment familiar and comfortable for the applicant in order to gain the greatest insight regarding the applicant's behavior, needs, and abilities; the need for emergency intervention; or the availability of an informant. Based upon what is known about the applicant and his or her circumstances, consideration of the above factors may indicate that one setting is more expedient, or that one setting may yield the most relevant information.

- D. It is not intended that the intake worker will make a diagnosis of mental retardation/autism or pervasive developmental disabilities (PDD). The primary purpose of the intake is to gather information in order to determine eligibility. In addition, information is collected to assist in preliminary service planning. To these ends, the intake worker shall:

1. Collect pertinent demographic data
2. Determine the nature and type of services already provided to the person
3. Identify service needs
4. Collect information regarding developmental history and current living arrangements
5. Determine what information will be needed to establish eligibility
6. Provide the referral source an opportunity to receive an explanation of Developmental Services
7. Provide services or referral for singular immediate needs particularly regarding health and safety.
8. Begin to gather information for a service plan.

IV. Intake Documentation

- A. The intake worker is responsible for the completion of various required documents.

The forms to be completed include:

1. The information sheet on EIS
2. The Permission for Service;
3. The Release of Information, (to);
4. The Release of Information, (from), as required; and
5. Intake assessment.

In addition, the intake worker will arrange for a psychological evaluation unless current copies can be obtained from another source.

- B. Information Sheet

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The information sheet (EIS) is completed at the intake. The form serves as a source of information regarding the applicant. Upon acceptance of the applicant for services, the form will become the face sheet for the case record.

C. Release of Information (to)

This form gives permission for Developmental Services to release specific information to a designated person or agency. A separate release is required each time information is disclosed. The original signed release stays in the case record.

Only records or information which are generated by Developmental Services and which will not be harmful to the consumer may be authorized for release. All such information shall be stamped "Privileged and Confidential Information, Not to be Used Against Client's Best Interest".

E. Release of Information (from)

This form authorizes the release of information generated by the primary source to Developmental Services. The release is specific to the agency noted in the release and the information requested. A separate release should be completed for each agency from which information will be requested. It should be understood that the release form authorizes the one-time release of information from the primary source, and that the authorization is specific to the information specified on the form. When requesting additional information from a particular agency, a new Release of Information form should be completed. The intake worker should insure that the "to" section on the release is filled in prior to asking an applicant or legal guardian to sign. The original signed form will be sent to the agency from which information is requested.

F. Intake Assessment

This document provides the structure to the assessment phase of the intake process. It provides a basis for a psychosocial evaluation of the prospective person.

V. Establishing the Need for Evaluation

A. An updated psychological evaluation may be requested at the discretion of the Regional Supervisor in order to determine a diagnosis of mental retardation/autism. This may be particularly necessary in the referral of children transitioning to adult services considering the potential for growth and achievement. A licensed Ph.D., psychologist or a licensed psychological examiner, must conduct the evaluation. Additional professional assessments may include physical examination, psychiatric evaluation, physical therapy evaluation, occupational therapy evaluation, speech and hearing evaluation, etc. Foreign language and/or sign language interpreters must be utilized whenever there is a communication barrier to comply with Federal and State Laws concerning equal access to service.

C. The intake worker, through observation and interview, may determine areas where further evaluation may be useful. Certain professional evaluations may be indicated solely on the

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basis of the timeliness of the available information. Other needs for evaluation may become obvious during the intake process. Evaluations requested that are not directly related to determination of eligibility should not delay a decision being made within the accepted time frame.

- D. The intake process should be completed within 90 days. The end date for completion is date of a letter of eligibility. If the process can not be completed within 60 days a letter will be provided to the applicant explaining that eligibility has not been determined and providing specific information as to why with a projected completion date. The office of Advocacy will be notified. If at the projected date the eligibility cannot be determined the applicant will be contacted again in writing explaining the reason for a decision not being made with another projected date. The office of Advocacy will again be notified.

VI. Disposition of a Referral

- A. Once the intake worker has completed the intake assessment and other necessary forms, and has obtained a current psychological evaluation, the intake worker will meet with the regional supervisor to discuss all of the relevant information obtained by the intake process.

B. Denial of Services

1. If the Regional Supervisor determines that the applicant does not meet the established criteria, (See Eligibility for Developmental Services in Case Management Manual) the person will be denied Developmental Services. To the greatest extent possible, the intake worker and the Regional Supervisor will attempt to suggest to the applicant or to the referral source, alternative services.
2. The applicant and/or the individual acting on behalf of the applicant shall be informed of the denial in writing and when necessary via other appropriate means, and given notice of their right to appeal that decision and of the availability of the Office of Advocacy to provide assistance. (See Eligibility for Developmental Services in Case Management Manual)

C. Acceptance for Services

1. If the Regional Supervisor determines that the applicant meets the eligibility criteria, he or she will be accepted for Developmental Services. The Regional Supervisor and intake worker will determine the case management status based on the criteria in the case status procedures.
(See case management status procedures active, inactive, closed in case management manual.) The person will be informed in writing of their eligibility and will be provided with:
 - a. A statement of rights, information about the grievance process and the availability of the Office of Advocacy;
 - b. Information about the case status to which the person has been assigned;
 - c. If assigned to Active status, the name of the CM and contact information. For all other statuses, the name and title of a person to contact.

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2. A psychosocial will be written by the intake worker for transfer to case management or to the person covering the inactive case status.
3. The intake worker for transfer to case management or inactive case status will write an initial service plan. (If an applicant had not met with a representative of the department until acceptance, a meeting will occur at this time to review needs and develop a service plan.)

Section III Legal

Clients Rights

Assuring that a person's rights are protected is one of the most critical case management functions of DHHS. Below is a list of case management tasks associated with safeguarding peoples rights.

Case managers are responsible for:

- Assuring that person receive an explanation of their rights in understandable terms at intake.
- assuring that the persons' family or guardian receives an explanation of rights and written materials, if desired,
- assuring that providers of service to the person are familiar with the law,
- monitoring the person's enjoyment of these rights through routine case management,
- Reporting any allegations of the denial of these rights to the Office of Advocacy or in the case of children, to the department of Human Services.

On the following two pages (Grievance and Appeal and Legal Considerations) is a list of the rights of Maine citizens with Mental Retardation adopted from Title 34 - B of the Maine Revised Statutes Annotated, Chapter 186-A, intended as a guide to caseworkers when explaining their **rights to the individual**.

Grievance and Appeal

It is the policy of DHHS to ensure that needed services are provided to persons with mental retardation in accordance with the laws of Maine, to the extent resources permit. Further it is the policy of DHHS to provide for review of a decision in which a person is denied a service.

All persons and/or their representative who are eligible for services shall have the right to appeal any action or inaction of DHHS related to or involving rights afforded by state or federal law, Departmental rules, regulations or policies. Consumers of services shall be notified annually that they have the right to appeal any action or inaction.

The Developmental Services GRIEVANCE AND APPEAL PROCESS is an established policy and can be obtained from any of the Regional Offices in policy or brochure. The brochure was produced for consumers and families and states clearly in plain language how to process an appeal.

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Legal Considerations

A number of protections have been afforded people eligible for Developmental Services through the laws of the State of Maine. This section of the Manual describes DHHS practices in carrying out its legal mandates.

The Laws that you, as a case manager, should be familiar with are:

34 B MRS. subsection 5431 et. seq.	Community-Based Services for Mentally Retarded Persons.
34 B MRS. subsection 5601 et. seq.	Rights of Mentally Retarded Persons.
34 B MRSA subsection 5461 et. seq.	Process for Provision of Developmental Services
34 B MRSA subsection 5002 et. seq.	Declaration of State Policy
22 MRSA subsection 3470	The Protection of Incapacitated and Dependent Adults
Dependent	
34 B MRSA subsection 5474-7	Involuntary Admission
34 B MRSA subsection 7001	Sterilization
34 B MRSA subsection 5477	Emergency Procedures for Admission
34 B MRSA subsection 5475	Judicial certification
34 B MRSA sub section 1218	Accessibility to Developmental Services for Persons who are Deaf or Hard of Hearing
	Marriage
34 MRSA subsection 1207	Law on Disclosure of Client Information
18 A MRSA subsection 5-601	Guardianship

All of these laws are available at each Department Regional Office or can be accessed through the State of Maine Home Page.

The Rights of Maine Citizens with Mental Retardation

(This straight forward explanation of consumer rights, adapted from 34 - B MRSA Chapter 186-A, is intended for use by consumers and providers.)

I would like to tell you about the law that says how other people are supposed to treat you. This law says that you have the right to do certain things, and there are other things which no one can make you do. For example:

1. No one can tease you or make fun of you. You can tell them to leave you alone if they do.
2. No one can stop you from going to church or saying prayers if you want to.
3. No one can read your mail unless you say it's O.K. No one can stop you from mailing a letter.
4. No one can stop you from using the telephone, TTY or fax machine and no one can listen to your

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phone calls unless you say it's O.K.

5. No one can stop other people from coming to visit you, and no one can hang around when you have company unless you say it's O.K.

6. If you have a job, you have to be paid fairly according to existing laws. You can ask your caseworker for details.

7. No one can stop you from voting, and no one can tell you who to vote for. After you vote, no one can make you tell who you voted for unless you want to tell.

8. No one can take away your clothes or money, or touch any of your things unless you say it's O.K.

9. No one can take away your food to punish you or to be mean to you.

10. No one can stop you from going to the doctor if you don't feel well or to the dentist if your teeth hurt. No one can stop you from asking the doctor to come see you if you don't have a way to get to his/her office. If you want to see the doctor or dentist, just ask. No one can make you go the doctor or dentist if you don't want to go.

11. No one can make you take medicine to punish you or just to keep you quiet or sleepy.

12. No one can stop you from talking to other people.

13. No one can stop you from going outside to walk around or going to the movies or things like that.

14. Nobody can hit you or hurt you for doing something wrong.

15. No one can hold on to you against your will unless they are sure you are going to hurt yourself or someone else. No one can hold you against your will just to punish you or be mean to you.

16. No one can put you in a bed with bars on it unless it is to protect you from falling out.

17. You have a right to see anything that is written about you. All you have to do is ask. No one can show these records to anybody unless you say they can.

18. You have the right to get together with the other people you live with and to form a group to make your needs known to those who own and run the place you live and work in.

19. Before anyone can put you in an institution such as Dorothea Dix or the Riverview Psychiatric Center they have to prove to a judge that you need to go to an institution, and that an institution is the best and only place for you at the time.

20. If you think someone is trying to stop you from doing any of these things or isn't treating you the way they are supposed to, you can tell your caseworker or someone who is your friend to help you make them stop treating you wrong.

21. No one can talk about you to others without your permission.

22. If you use sign language or gestures to communicate, you have the right to work, live, and relax with other people who can sign to you and can understand your signs and gestures.

Services from the Attorney General's Office

The Attorney General's office assigns Attorneys to the DHHS. The Attorney General's office provides legal services on issues affecting both staff and eligible persons. Caseworkers who have a need for immediate legal advice are encouraged to consult with their supervisor. The supervisor may feel free to contact the AG's Office directly; however, because issues requiring AG involvement generally have broad implications for DHHS operations, the supervisor should inform the Team Leader or Program Manager who will keep the Commissioner's office and others informed as appropriate. This assures that legal advice can be integrated into the Department's policies and practices.

It is not unusual for the CMs to encounter situations where legal requirements need some interpretation. In order to funnel the flow of requests for legal services, and in an effort to expedite the answers to questions, here is some guidance:

For individual situation with guardianship or adult protective considerations where there appear to be legal issues:

- a. Consult your supervisor,
- b. If you and your supervisor are unable to resolve the problem, consult the Guardianship Program Manager or Adult Protective Services Manager who will refer the situation to the AG's office, ongoing communication regarding that case would be between the case manager or supervisor and the Assistant AG.
- c. Once an individual situation has been funneled to the AG's office, ongoing communication regarding that case would be between the case manager or supervisor and the Assistant AG.

For individual situations that do not involve guardianship or adult protective considerations, where there may be legal issues:

- a. Consult your supervisor,
- b. If you and your supervisor are unable to resolve the situation, or when you are simply uncertain about an answer, the case manager should feel absolutely free to call an AAG to discuss the question.
- c. Once an individual situation has been referred to the AG's office, ongoing communication regarding that case should be maintained by the case manager.

In emergency situations, where local supervision or appropriate central office staffs are unavailable, contact should be made directly with the AG's office.

Sterilization

In 1982 the Legislature passed a law entitled "Due Process in Sterilization Act of 1982". See 34 B MRSA Subsections 7001-7016. The Legislature, recognizing the irreversible nature of sterilization, intended "to prevent discrimination and unnecessary sterilization, and to assure equal access to desired medical procedures for all Maine citizens.

The law currently requires that the person requesting sterilization give to a physician their "informed consent". Informed consent is based on an actual understanding of the nature and consequences of sterilization, its risks, and benefits, and an understanding of the alternative methods of contraception. There must be neither expressed nor implied coercion in giving such consent. A due process hearing in Maine District Court is necessary to determine a person's ability to give informed consent, if the person is under 18 years of age and not married, or a resident of a state institution providing their care, or under public or private guardianship, or someone from whom the physician could not obtain informed consent.

Finally, if there is any chance that sterilization may be seriously pursued, the case must be discussed with (at a minimum) the Developmental Services Team Leader and an AAG. Case Managers should not become involved in explaining legal requirements to parents, persons, or guardians. Sterilization requests should be referred to the person's guardian. If the guardian is the one requesting information on a ward's sterilization, the CM should recommend that the guardian discuss the matter with an attorney. Sterilization of a person is a legal matter and can only be resolved by the courts.

Section IV Case Management Procedures

Action Notes/Contacts

Case Managers are expected to maintain regular consumer contacts, and to maintain regular action notes. Both contacts and action notes should be at least monthly, unless otherwise specified (see below). All Community Consent Decree contacts and all consumer monthly billings must be supported by an appropriate action note, which is documented by the Case Manager using the standards outlined below.

All action/contact notes are to be done on the EIS system effective 10/1/03

Contacts should occur often enough to assure that the Case Manager remains apprised of the consumer's status and well being, as well as maintaining familiarity with any providers who are serving the consumer. Whenever applicable, the Case Manager should arrange his contacts so that he visits the consumer in the full range of settings in which the consumer lives, works, and socializes.

Face-to-face contacts are preferred, but a phone contact may be substituted if scheduling conflicts prevent a direct visit, or if the consumer does not wish to have direct contact with the Case Manager. In either of these cases, the Case Manager's action note for the month should reflect this fact. Email contact can occur but should not be a routine means of contact with the consumer. Email contact with family, guardian, providers etc can be an effective means of communication. Portions of this communication can be pasted into a contact note in order to provide direct and pertinent information. The entire email should not be pasted and an introduction and final statement should be included in the contact note by the case manager.

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Action Note Requirements (2003 Action Note Training)

Web Based Training- <http://www.ipsitech.org/doc/>

Minimum:

1. Sign (full name-classification "CM,")
2. Date (full date-month, day, and year)
3. Link to plan when relevant

Action Notes:

1. Place of contact
 - Residence, vocational, etc.
2. Type of contact (and who was present)
 - Face-to face, telephone, collateral, etc.
3. Observation
 - Issue(s) events surrounding quality of life areas, changes in medical and dental condition, etc.
4. Action
 - Action(s) that have taken place or take place in the contact
5. Follow-Up
 - Action(s) that need to take place
6. Signature and date (will eventually be provided automatically in EIS)

Action notes should be done at least monthly, and in conjunction with the date of the monthly contact.

Notes should include:

- PCP or other significant meetings and follow up documentation related to these meetings.
- A summary of the contact and the overall status of the consumer as observed and/or described.
- Ongoing notations on any problematic or unresolved issues. Longstanding patterns with frequent recurrences (e.g.), rep payee disagreements, arrests, substance abuse episodes may be noted with a brief notation, so long as there is a longer, characterizing summary included in the notes at least biannually.
- Any major or life-altering events, both positive and negative.
- Any changes in family or marital status
- Significant actions undertaken by the Case Manager or other members of the team, relative to the consumer's services.

Action notes must always include a signature and date. They should be prepared as soon as possible after the contact in any case, within 10 workdays.

Action Plan Procedures 10/02

Person-Centered Planning is a process that assists and supports each person in creating a vision for how to live in and be a part of the community. Through the pre-planning and planning process, the planning team works with the person to articulate and identify specific Needs and Desires within the larger framework of the person's vision for the future. All Needs and Desires shall be addressed in Action Plans in accordance with the following procedures.

A "Need" is something identified by the consumer/guardian and the team that is required to maintain or improve a person's quality of life and should to be met within a specific time frame. Examples are housing,

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employment, day services, medical, and other professional services, respite, leisure, family support, transportation.

A "Desire" is anything else the person wishes to achieve/have/obtain, which is not a Need. Whether a goal is categorized as a Need or a Desire will, at times, depend on the person's circumstances. A Desire for one individual may be a Need for another person.

The team with the consumer/guardian leading is responsible for deciding what is identified as a Need, and what is identified as a Desire. These determinations are not final and irrevocable and what is identified initially as a Desire may, with a change in circumstances, later be reclassified as a Need. In this process, the team should be mindful that Person-Centered Planning is driven by the person.

Once identified and articulated, all Needs and Desires shall be recorded in the Person-Centered Plan without regard to whether they are reasonably achievable or presently capable of being addressed.

All Needs and Desires must then be recorded in an Action Plan attached to the Person-Centered Plan. Within the Action Plan the team must identify the following: 1) specific action steps required to meet the Need or Desire; 2) time frames for each action step, for reporting on progress, and for ultimately meeting the Need or Desire; and 3) persons responsible for action steps and reporting. The team shall monitor the person's Needs and Desires on an ongoing basis in accordance with the Action Plan. Desires will be addressed in the Action Plan process in the same manner as Needs except as stated in paragraph 8 below.

It is expected that, when the required resources are available to the team, most Needs shall be met within 90 days. It is also understood that for some Needs, such as housing and employment, a time frame of 90 days or less may be unrealistic even when all required resources are available to the team. Whenever the team identifies a time frame greater than 90 days, it must provide an explanation in the Action Plan for why the Need cannot be met within 90 days despite the availability of all necessary resources. Time frames may be adjusted only when necessary, due to the consumer's inability or unwillingness to participate.

A Need will be identified and treated as an "Unmet Need" when it has not been met within the time frame set by the team or whenever the team has determined, at any point in the process, that a resource required to address the Need is not available.

Once an Unmet Need is identified, the team must prepare an Interim Plan for providing services and supports that come as close as possible to meeting the Need in the interim while the team pursues the required resources for meeting the actual, identified Need. Within the Interim Plan, the team must identify action steps, time frames, and persons responsible for action steps and reporting. The Interim Plan becomes an adjunct to the Action Plan.

The team is obligated to conduct interim planning for Desires within the Action Plan. If the team determines that a resource required to address a Desire is not available, the team must develop action steps within the Action Plan that address the Desire as nearly as possible in the interim while the team pursues the unavailable resource.

These guidelines are designed to empower the team in supporting the person regarding Needs and Desires. Person-Centered Planning is driven by the person or the person's guardian. The person and/or guardian provide the direction to the team. Other members of the team provide input, support, and guidance to the person regarding Needs and Desires and the planning process in general. If there are divisions between the person and team members, then the person's request should be honored to the extent possible except for reasons of health or safety. Team members always have the choice to not support the conclusions of the team by not signing the Plan. If there is a division between the person and the guardian or family members that cannot be resolved then mediation support is a suggested way of attaining resolution. When team members cannot reach consensus on an issue and the person or guardian has not expressed a preference on the matter, a majority vote of team members will control.

If a person or the person's guardian is dissatisfied with any part of the Plan or the planning process, they have the right to appeal in accordance with the Department's appeal procedures. The person or guardian may obtain assistance from the Office of Advocacy to file or pursue the appeal.

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The Case Manager shall be responsible for ensuring that the Person-C entered Planning process is conducted in accordance with these procedures and shall be responsible for monitoring the planning process in accordance with the Case Management Manual and the Consent Decree.

See Person Centered Planning Preparation/Procedure Guide (5/30/01); Implementation and Facilitation Manual for Person Centered Planning (May, 1996); and Planning with People (Feb. 1995).

Under the Community Consent Decree case managers are to be alert to program or funding changes that may adversely affect a person's residential, employment or day service when such changes are not the result of a person's planning process. An example of this is a change in allocation allowances for a certain service in the Home and Community Based Waiver Program. If such program changes occur, the case manager should report the change to their Team Leader. The Team Leader should relay this information to the Director or her designee.

*** Please refer to Appendix A to review a letter sent on August 15, 2008 to all Class Members. "Your Rights if Mainecare Stops Paying for Services You Need".**

2. For Class Members, a Need includes any service or circumstance that the Department is obligated to provide under the Consent Decree.

How and whether Desires are to be addressed in Interim Plans (sometimes referred to as "Bridge Plans") has been a matter of some confusion and inconsistent treatment in Department training materials. With respect to Class Members, the Consent Decree states that the team shall develop interim plans that address Needs or Desires as nearly as possible. Decree, Article VII.1. The Decree also requires certain record keeping for Unmet Needs but not "unmet desires." "Interim Plan" documents will now be used for Needs and not Desires to facilitate accurate record-keeping of Unmet Needs and the resources required to meet them. The obligation to conduct "interim planning" for Desires will, however, be performed within the Action Plan process.

Computer Proficiency (DHHS Employees)

It is the Department's expectation that all Case Managers will achieve and demonstrate basic proficiency in the following skill areas:

1. Utilization of E-mail, including the ability to open messages, send messages to individuals or groups, locate addressees in a directory, open attachments, send attachments, and send replies to both individuals and groups.
2. Utilization of the EIS systems. Ability to access information, make changes on individual records, and generate reports.
3. Utilization of scheduling programs, particularly to schedule conference rooms or meetings.
4. Proficiency in using word processing programs, including the ability to move around within a document, make changes to an existing document, and generate or save a new document.

The Department will periodically assess the skill level of Case Managers, and will provide ongoing training. This training is mandatory for all Case Managers until they can demonstrate proficiency in the four areas listed above.

Co-Case Management (DHHS Employees)

There are at three least situations in which Case Managers may find it productive to engage in Co-Case Management for a particular consumer:

1. In a mentoring relationship, particularly when one of the Case Managers is either new or unfamiliar with the types of issues presented by a new consumer on her caseload.
2. An advisory or second-opinion relationship, particularly if a contentious or difficult dynamic has developed between the original Case Manager and the consumer or family member.

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3. As a means of dividing labor. For example, one Case Manager may be specialized or adept at accessing housing resources, while another is particularly good at preparing proposals; these Case Managers may elect to divide their work so that one of them provides a particular service for consumers on both caseloads.

Any of these forms of Co-Case Management are acceptable, subject to the following provisos.

- A supervisor must be aware of and approve the arrangement.
- One Case Manager must be identified as the primary Case Manager, on the EIS, in the file, in the action notes, and in all contacts with the consumer and the family.
- The consumer and family must be made aware of the Co-Case Management arrangement, and, in all but exceptional cases, must agree to it. If their agreement is waived, this must be done by the Developmental Services Team Leader or designate.
- The consumer must be counted on one of the Case Manager's ratios, but not both.
- The Case Manager of record must do billing, where applicable.
- Co-Case Management should continue for only so long as it is agreeable to both Case Managers.

Case Management Transfer Policy

Purpose- The purpose of this policy is to provide guidelines in the transfer of case management services when due to consumer choice of another provider, a conflict of interest necessitating a change in provider, or the need for state case management.

Procedure

1. If a consumer/guardian chooses to change case management services the providing agency will assist the consumer/guardian in identifying other potential providers and share pertinent information with releases. The transfer of case management responsibilities will be under the direction of the consumer/guardian. It is suggested that a transfer meeting occur with the person and the agencies involved. A transfer date will be identified. Case Management billing can only occur once within a month, and cannot be billed by two agencies providing adult case management services within the same month. It is the responsibility of the sending and receiving Supervisors to assure a smooth transfer of information both electronic and paper files. In the case of transfer of a Community Case Management case to another region for like service it is the responsibility of the sending Community Case Management Agency to inform a Regional Supervisor in their region that a consumer is transferring to another region. The Regional Supervisor will then have the regional file (typically the intake information) transferred to the region in which the person is now residing.
2. If a consumer chooses another contracted service from the agency providing case management services (i.e. day habilitation) they must transfer to another agency for their case management services. This transfer will need to take place as soon as possible, but no later than 90 days from the start date of the other contracted service being provided. Within that time period, the agency will be able to bill for the case management service.
3. People receiving case management under Children's Services can transition to adult services between the ages of 18-21. The person must be found eligible for Adult Developmental Services and can do so starting at age 18. When the person/guardian decides to transition to adult service case management the Children's Services case manager can assist the person in remaining with that agency if it provides adult services or seek an alternative. The person/guardian can also contact Developmental Services for assistance in linking to a provider. A transition meeting will need to occur with the person and the case management agencies. Billing can occur for one-month overlap between Children's and Adult case management to support the transition.

Consumer Files/Record Keeping

Keeping an accurate and current account of significant events in our consumer's lives, services provided, and evaluations performed are extremely important. Good record keeping can greatly enhance the continuity of case management services by accurately reflecting that the wishes of our consumers are the focal point of all services requested and provided.

The case record should include, but is not limited to, the following;

1. Relevant demographic information is maintained in E.I.S..
2. If the consumer is deaf, non verbal and signs or is familiar with another spoken language the name and contact information regarding a qualified interpreter or individual who is familiar with the consumer's communication style.
3. Copies of the most recent and pertinent evaluations (i.e.; psychological, psychiatric, O.T., P.T., Speech, etc.).
4. Medical and dental information. Indicate where primary medical information is (i.e.: residential file at supporting agency).
5. Copies of the individual's annual plan/behavior protocols, if used.
6. Action notes are maintained in the E.I.S.
7. Guardianship information
8. Evidence of any legal/judicial involvement
9. Correspondence
10. Copy of mortuary trust/funeral arrangements, if any
11. Certification materials for the waiver program, if applicable/other housing information
12. Financial information/SS/SSI/VA/RR etc.
13. Quality assurance/consumer satisfaction information
14. Information on best method for communication, preferred interpreter, or where to locate a "dictionary of communicative intent" for individuals with unique communications styles.

Consumer/Case Manager Relationship

One of the Case Manager's primary tasks is to assist and support the consumer in planning his/her life. The Case Manager needs to assure each consumer receives an opportunity to participate in personal planning, regardless of intellectual capacity or communication barriers.

Case Managers enjoy a very unique relationship with consumers, a relationship that is in large part determined by the needs of the individual consumer. For some consumers, the relationship needs to be supportive and non-directive, for others the Case Manager needs to assert more responsibility. The foundation of relationships between the CM and consumers lies in the CM's role in "monitoring" the consumer's well being. Monitoring is done through personal contact and phone calls to the consumer, his/her family, and involved support staff. The frequency of this contact is determined by the consumer need, request, problems, type of program, and the personal planning process. In the case of "class members" (i.e. individuals who were former Pineland Center residents), CM's shall contact each

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such consumer once a month by phone and at least twice yearly in person. Contacts with consumers should occur in both the home and the day program/work setting. Often, there are different issues for the consumer in each environment.

During the course of the Case Managers contact with the consumer, attention needs to be paid to the consumer's:

1. programming/work needs
2. physical well-being
3. emotional well-being
4. social well-being
5. environment (home & work)
6. communication with staff, family and peers

Additionally, it is important for the Case Manager to develop positive relationships with the consumer's primary support staff, family, and guardian. This will facilitate good communications to support the consumer's well being.

Consumers with Dependent Children

There are cases when a consumer served by Adult Developmental Services has one or more children. In some of these cases, other Offices within DHHS may be involved, even to the extent of pursuing protective custody of a child. The Adult Developmental Services Case Manager's responsibility in such cases is primarily to the adult (i.e.), the parent. In adversarial cases, it is expected that DHS will advocate for the child, and Developmental Services for the parent. The Developmental Services Case Manager shall not, either by commission or omission, contribute to the potential endangerment of the child. Indeed, the Case Manager has the same legal obligation as any other professional to report instances of suspected abuse or neglect. However, once any proceeding is underway, the Case Manager's obligation is to assist the consumer in getting legal counsel and therapy, when indicated. Further, the Case Manager is obligated to ascertain and acknowledge the consumer's wishes, and to assist the consumer in exploring any course of action that realistically offers a chance of actuating those wishes. The Case Manager is expected to advise her supervisor of all such situations, and in turn, either the supervisor or the Case Manager is expected to notify the Office of Advocacy.

Coordinator or Transition of Children Under OCFS Care to the Adult Service Programs Under Developmental Services or OES

October 2002

Note: This protocol covers youth with identified diagnoses of mental illness, youth with mental retardation and youth who are in need of adult protective services who will transition from youth services to adult services. This protocol also covers youth served by DHHS children's services systems.

Introduction

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The Department of Behavioral and Developmental Services (BDS)*¹ and the Department of Health & Human Services, Office of Child and Family Services (OCFS) and Office of Elder Services (OES) are often serving people who are receiving supports from both agencies or who require a close collaborative working relationship to plan services for people leaving the OCFS children's service system and entering the DHHS or OES adult service system. In the first instance this refers to children who are in the care and custody of DHHS but who also need services or supports offered through DHHS Children's Services system. In the latter instance this refers to young people who are between the ages of 18 and 21 and in the care and custody of DHHS and who require services from the adult system of OES.

Both Departments are committed to providing a close collaborative working environment so that we can plan together and share our expertise to well support children and youth who are consumers of State services.

In setting forth this Protocol, the Departments reaffirm their commitment to providing the best services and supports possible by building on the strengths of their mutual work.

Purpose

The purpose of this Protocol is to set forth expectations and agreements that form a pathway to guide our work together, acknowledging and building upon excellent regional collaboration. In helping youth transition to adult services, collaboration, consumer-focus, information sharing and planning become the most crucial components.

Agreements

OCFS, OES and DHHS agree that timely notification of transitioning youth and timely responses to requests for eligibility determination are critical to establishing a well-planned transition for youth to needed services. A conflict resolution process for staff of all agencies is also a key component to effective working relationships.

- DHHS and OES will use a standard information and referral form in all regions across the state. The form will contain space to include the youth's specific need for services as they approach the age of 18.
- DHHS and OES eligibility criteria will be available and clearly stated so that OCFS staff will know the criteria that may qualify a youth for adult or children's services.
- OCFS will provide information on youth who will need services to DHHS and/or OES between the ages of 16 and 16 and a half. The information form will be at the DHHS/OES regional office no later than six months after the youth's 16th birthday. The information form does not constitute a referral. DHHS/OES may, upon request, look at appropriate information to advise on the likelihood of eligibility (advisory eligibility) and to identify the need for further information.
- Eligibility determinations will be made starting at approximately age 17, upon receipt of a referral, although actual adult services may not begin until age 18 or at a later agreed upon age for transfer. OCFS will receive a written response with regard to the referral to DHHS/OES within 3 months of the formal referral clearly stating the reasons for acceptance or

¹ DHHS refers to Children's Services, Adult Mental Health Services and Developmental Services.

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non-acceptance of the referral. This will enable OCFS staff to have the time necessary to explore other transition plan options if the youth is not accepted for services under DHHS. If the process cannot be completed within 3 months a letter will be provided to the applicant explaining that eligibility has not been determined and providing specific information as to why with a projected completion date.

- If a youth is determined to be eligible for services as an adult, staff from the appropriate Departments will work together, prior to the youth's 18th birthday, to identify and review the services that the youth is expected to need under adult services. For youth who qualify for services under DHHS, the DHHS case manager will be assigned and introduced to the youth to begin the relationship building process with the youth as early as possible but no later than 3 months prior to official transfer.
- For eligible youth, commitments from all state agencies involved will be clearly stated in a transition plan document. Considerations in the planning process include:
 - Commitments regarding services that are needed and available
 - Funding commitments, including timeframes
 - Guardianship need
 - SSI and other benefit status, including plan for application with timeline
 - Date of transfer (adult case manager assigned)
 - Any other specific actions needed, with identified responsible party
- Youth who have been declared ineligible for DHHS mental health or Developmental Services will be advised of the eligibility decision appeal process and the time lines for completing this process.
- There will be a conflict resolution process available for those issues that are outside of the eligibility determination. This process will be conducted within 3 months of the disputed decision. A conflict resolution protocol will be developed and used by staff from DHHS, OES and OCFS. OCFS district Program Administrators, DHHS regional Team Leaders and OES Protective Program Administrators will approve any requests for initiating the conflict resolution process.
- A committee with representatives from OCFS, DHHS, OES and other involved systems in each district will meet at least on a quarterly basis to review the status of referrals.
 - Local contacts for each program area (MH Services, Developmental Services, OES, Children's Services and OCFS) for information and referral will be designated locally.

DHHS, OCFS and OES agree that collaborative training, information sharing and resource development activities are also key components to effective working relationships and best practices for youth and families.

- DHHS and OES will provide available resource directories and provide information on the array of available services to OCFS staff.

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- The quarterly meetings agenda will include items related to information sharing and resource development. Other agenda items may include the process and criteria for determining eligibility and managing waiting lists, strategies for accessing needed services, listing of adult service contract providers.
- In addition, DHHS, OES and OCFS will extend invitations to one another to attend relevant training events.
- OCFS, OES and DHHS will develop a tracking system so all systems can know at any point in time how many young adults are being considered for transfer between programs and Departments.
- Any children's resource development activity that requires the adult system to continue funding after transition will be coordinated with DHHS or OES to assure that funding criteria and responsibilities can be planned for and met.

The parties to this agreement will meet annually to review the status of the agreement.

Director, OCFS, DHHS

Program Director, Developmental Services, DHHS

Program Director, MHS, DHHS

Program Director, CS, DHHS

Director, OES, DHHS

Program Director, APS, OES, DHHS

Regional Director, R1, DHHS

Regional Director, R2, DHHS

Regional Director, R3, DHHS

Date of agreement _____

Review due _____

Critical Information sheet protocol

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In order to assure that all consumers receive the highest quality of service possible it is recognized that certain critical information, , must be readily available and accessible to case managers, crisis service staff and health care providers. This information will be made available in EIS in the critical information section.

This sheet will be completed and updated for all Class Members by April 1, 2001 ?? and will be updated according to the following schedule:

1. For all class members, as part of the monthly consumer contact, information will be reviewed, changes will be documented and updated on the EIS in the critical information page within 48 hours.
2. When individuals change residence the current critical information sheet will be attached to the consumer movement sheet that outlines the steps necessary in facilitating a residential move. The information must be updated on this sheet as a routine part of a residential move.
3. At the PCP meeting the team must identify a person responsible for updating the critical information and to be responsible for assuring that information gets updated as things change and for reporting changes to the Case Manager.

Final document updated 3/20/01.

Deaf Services

Services provided by the department will be designed and implemented to meet the needs of individuals who are deaf, hard of hearing, or hearing/non-verbal signing. This will include the following services or activities:

1. Appropriate assessments to determine an individual's hearing level and preferred mode of communication will be held. Individuals who are deaf, hard of hearing or who have neurological or physical damage precluding the acquisition of speech shall be taught sign language or an alternative communication system.
2. At appropriate intervals individuals will be reassessed to determine changes in hearing level or need for alternative forms of communication.
3. Individuals whose preferred form of communication is American Sign Language or other signing/visual gestural system will have a qualified interpreter available for any meeting involving the individual and staff of the department.
4. Each Regional Office and major sub-office shall retain the services of at least one case manager who is fluent in American Sign Language and other manual communication modes and knowledgeable about deaf culture and who will be responsible for coordinating services to individuals who are deaf or hard of hearing in that region.
5. Appropriate environmental modifications including intensive sign language training to staff and person peers will be made in all residential facilities and day programs where individuals are deaf or hard of hearing.
6. Families, house mates, and neighbors of individuals who are deaf or hard of hearing will be offered training in the alternative communication form used by their family member who is served by this department.
7. At each person centered planning meeting involving an individual who is deaf or hard of hearing appropriate plans will be made to work on the communication needs of that individual and

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his/her supports. Case Managers must ensure that plans developed are monitored regularly to ensure appropriate follow through.

8. The department will work with providers in order to ensure that staff who work with individuals who are deaf or hard of hearing have qualified staff to work with them, including appropriate qualifications or training in the form of communication used by the individual.

Death of a Person Receiving Developmental Services

A notification procedure upon the death of a consumer is important to assure quick and effective notification to family members, guardians and other significant persons in the consumer's life.

Notification Protocol

Responsibility of the provider.

1. Each provider of services that receives funding from the DHHS shall establish a notification procedure to be utilized in the event of the death of a person receiving services.

This procedure must include:

- a. That the CM, Case management Supervisor, Developmental Services or Team leader be notified immediately after the death of a consumer. After hours, the crisis prevention and intervention worker must be notified immediately. This is done through the reportable events process
- b. After a death the provider should notify, ASAP, the next of kin, guardian, correspondent and any significant persons in the consumers life.
- c. Determine who should make funeral arrangements and proceed accordingly.

The responsibility of the CM upon the notification of the death of a consumer should include the following procedure:

1. If the individual was not under guardianship and not receiving services from service provider receiving funding from the DHHS then the CM should:
 - a. Assure that any known next of kin, correspondent or any other significant person in the person's life are notified as soon as is practical.
 - b. Determine whether a mortuary trust exists and if so notify the appropriate funeral home.
 - c. If no mortuary trust exists then contact an appropriate Funeral Home and make arrangements making sure that the funeral home is aware that the individual is an indigent person if they do not have sufficient funds to cover the costs of funeral services and burial. These costs should be covered by the town of residence of the consumer through the Maine Municipal Association.
2. If the Department is guardian then the CM should:
 - a. Follow the procedures as outlined in the Guardianship Procedure Manual under **Death and Burial Expenses**.
 - b. Assure that any known next of kin, correspondent or any other significant person in the person's life are notified as soon as is practical.
 - c. Notify the Guardianship Office (287-6595) within the next working day of the death.

Case Management Status - Developmental Services

Active status for case management includes people who have been found eligible for Developmental Services and need a case management services as defined below. This determination, made by a Developmental Services Case Management Supervisor is a result of an assessment of their needs through the intake process or through the procedure for Transfer of Case Status. The person may be assigned to inactive or closed status if they meet the criteria. This determination can be made at the conclusion of the eligibility process.

Case Management Services includes the following:

- A. Assessment of the persons medical, social, educational, and other needs. This intake process will include the review of the results of the psychological evaluation; developmental and biographical history, behaviors, traits, and qualities; the persons current circumstances; the resources, services and accommodations provided to the person; the persons significant relationships, problems, requirements, and needs. The assessment will be coordinated by the Case Manager in consultation with the person, other professionals, providers, and family or guardians, as necessary. (See Eligibility and Intake procedure in Case Management Manual).
- B. Development and implementation of a Service Plan under the direction of the person and in accordance with the policies of DHHS.
- C. Coordination of the service providers and resources identified in the Service Plan.
- D. Linkage of the person with appropriate agencies, community resources and informal support systems, including referral to transportation services.
- E. Monitoring the person's progress toward the achievement of objectives specified in the Service Plan. The plan will be re-evaluated as often as is specified in the plan. The Case Managers will evaluate the person's status and needs periodically and implement changes in the plan of care, as necessary.

Inactive Status for Case Management

Inactive case management status assigned to people who have been found eligible for Developmental Services, receive services from the department, but do not require case management services at the present time because there is a reliable history of natural supports providing the case management functions. A Developmental Services Case Management Supervisor makes the determination.

The following describe some situations in which inactive case management may be appropriate:

- No legal involvement or if there is a legal issue the person has an attorney representing them.
- Not a class member
- A class member who has refused case management services. If annual follow-up is refused case will be placed in closed status.
- Not under public guardianship

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- Assistance in managing financial issues.
- Routine health care that is arranged without the assistance of a case manager.
- Not utilizing section 21 or 29 and no projected need for those services
- Healthy relationships with family, friends, natural supports
- No planning needed or receives from another source such as day program or housing
- Representative Payee – Service is provided by someone outside the Department.

Monitoring of Inactive Case Management Status

Each Regional Office will ensure the monitoring of people in inactive case management status. This may be done through a contracted service or by assigning a staff person other than a Case Manager with an active caseload. Monitoring will include at least an annual face-to-face contact with each consumer unless the consumer specifically requests not to be contacted. All such request will be documented. All contacts will be documented in the file. In addition a letter will be sent annually asking the if they are satisfied with the degree and scope of services being provided as well as reviewing their rights, review of the grievance and appeal process, and access to the Office of Advocacy. This letter will identify the regional contact person.

The Regional Office will ensure that:

- There are timely responses to requests made by individuals in this status
- Assistance in connecting individuals with services in their community is provided when needed.
- There is adequate monitoring of the level of need and recommendations made to the Case Work

Supervisor regarding the need for a change in case management status.

(See case status change procedure.)

Grievance and Appeal

Any concerns by a consumer or guardian in regards to this case status should be communicated to the Casework Supervisor and/or Office of Advocacy. The Grievance and Appeal procedure (14-197CDMR8) should be followed if agreement cannot be reached.

Closed Status for Case Management

Closed case management status is assigned to persons who have no further need for case management services. The following are situations in which a person can be in closed status in Developmental Services and the implications for accessing services in the future:

- A person who applies for services is found to be ineligible under 34B MRSA 5465 (refer to referral and intake policy). All intake information and reason for denial will be maintained in the Regional Office. If the person can provide additional information, primarily within the developmental period that indicates eligibility, the application can be reviewed. The individual has no access to funding or resources of Developmental Services if they are not found eligible for services.
- The consumer/ guardian after being found eligible for services chooses not to access any services. The consumer/guardian will be notified in writing of the case closure and informed that at any time they choose to reactivate services with the Department that they can do so, and would not have to go through the process of eligibility determination. Prior to closure the case will be reviewed by a Regional Supervisor to assure that information regarding service requests and PCP action plans were closed, reason for closure was clear, and that the person had been advised that

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services can be reactivated upon request. The Department may choose not to close a case if adult protective issues are present.

- The Regional Office determines that case management services are no longer needed and no other services are being requested or funded. The Regional Supervisor will review the case to assure that components outlined in Section 13, of the Maine Care Benefits Manual (Adult Developmental Services) or other services provided by the Department are not needed. The case will be reviewed by a Regional Supervisor to assure that information regarding service requests and PCP action plans were closed, reason for closure was clear, and that the person has been advised that services can be reactivated upon request.
- The person is eligible for services and moves out of state. Upon request, with appropriate releases, information will be forwarded to service agencies identified by the consumer/guardian. The case will be reviewed by a Regional Supervisor to assure that information regarding service requests and PCP action plans were closed, reason for closure was clear, and that the person has been advised that services can be reactivated upon request after returning to Maine.
- The person is deceased. The case will be reviewed by a Regional Supervisor to assure that information regarding service requests and PCP action plans were closed and the reason for closure was clear.

There is no responsibility for follow-up of cases placed in closed status by Developmental Services.

Discontinuation of Community Case Management

Discontinuation of Community Case Management may occur for several reasons including:

1. The needs of the individual no longer meet the criteria of active case management. (Refer to active case management in procedure manual).
2. The needs of the individual exceed the roles and responsibilities of a community case manager. (Examples include needing public guardianship.)
3. The person moves from the area or the state.
4. The person chooses to leave the organization that they receive case management services from.

Discontinuation of Developmental Services

If a consumer has been receiving case management services from Developmental Services for sometime, and it is determined that the consumer is no longer in need of case management services every effort will be made to link this consumer up with necessary community services prior to Developmental Services closure. The Case Manager (CM) will be responsible for making referrals to the appropriate community agency. Once referrals are completed, the consumer, guardian (if applicable), service providers, interested family and correspondent will be notified in writing by the CM that the consumer will no longer be provided Developmental Services case management services.

Similarly, if a consumer has been receiving case management services from Developmental Services for some time and it is determined that the consumer does not have a diagnosis of mental retardation or autism, every effort will be made to link this consumer with necessary community or Departmental

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services prior to Developmental Services closure. Situations such as these may include instances where a consumer was accepted for services on a conditional basis and where further evaluation resulted in the removal of the diagnosis of mental retardation or autism, or where a consumer without a diagnosis or mental retardation or autism had been accepted in the past for services and community services more appropriate to their needs (such as community mental health services) can now be accessed.

The regional supervisor, together with the case manager, will review the case and place the consumer in the "closed" status. The reason for closure will be documented in the case record and the EIS.

If a consumer is moving out of state, the CM, after receiving the necessary releases, will be responsible for forwarding appropriate information (personal planning process, clinical reviews, etc) to the receiving state agency. The CM will also notify the local service providers and correspondent that the case is being closed by Developmental Services.

Services may be discontinued at the request of the consumer, and/or the consumer's guardian, unless there are adult protective issues.

The status of the case should be clearly documented in the consumer's record and the EIS. For consumers /guardians who opt to discontinue Developmental Services services, notice should be given that they may reactivate services upon request.

Services may also be discontinued if the consumer has not received services from Developmental Services or 15 to 18 months. The status of the case should be clearly documented in the consumer's record and the EIS. Notice should be given that they may reactivate services upon request.

Dissolution of Accounts of Deceased Person's (Refer to DHHS Representative Payee Policy Manual

Family Support Policy

Policy# 98-PO-3

1. Purpose and Scope.

The Family Support Program provides financial assistance to the extent that resources permit to families who have adult family members with mental retardation or autism living with them.

The goal of the program is to provide the needed level of support in order to maintain the unity of the family and to support the family's desires and preferences for services within DHHS ability to meet all or some of those needs depending upon the availability of resources.

2. Authority: 34-B M.R.S.A. 5003

3. Procedures.

DHHS may reimburse eligible family members for services in instances where Developmental Services would have agreed to pay a non-family member to deliver the service.

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Family support includes a variety of services. Examples of family services include, but are not limited to, the following: respite care services, summer camp, recreation opportunities, transportation, after school care and arts and crafts.

Expenditures for family support services require prior approval from the Regional Office.

CASE FILE INDEX

The following material should be available in each client hard copy or electronic file.

Contents	Active File	Historical File
Critical Information Report EIS	Current	None
Planning Documents Person Centered Plan Individual Support Plan Individual Education Plan Crisis Support Plan Behavioral Support Plan Pre-Planning Documents Plan Reviews (semi, quarterly) Quality of Life Survey	Current year and 1 year past	4 years
Casework Notes Casework Action Notes EIS HHS Crisis Team Notes EIS Monthly Monitoring Form Site Review Form	Current year and 1 year past	4 years
Professional Evaluation Reports Psychology Counseling Occupational Therapy Physical Therapy Speech/Language/Communication Vocational Rehabilitation	5 years or most current	Keep permanently
Medical Reports	Current year plus 2 years	Keep permanently
Provider Summaries	Current year plus 1 year	4 years
Home and Community Based Waiver BMS 99 EIS Checklist Waiver Related Correspondence FSD Authorization	Current year plus 1 year	4 years
Choice Letter	Retain permanently	
Office of Advocacy and Legal Documents		
Information Release Authorization	Current Only	None
Guardianship Appointment Order	Retain Permanently	
HHS Annual Guardianship Plan	Current and 1 year past	None
Miscellaneous Legal Documents	Current Only	Keep permanently, unless time limited
Correspondence	Current and 1 year past	4 years
Financial Information		
Mortuary Trust		
Miscellaneous Financial Documents	Current and 1 year past	4 years

<p style="text-align: center;">Eligibility Determination Letter Permission for Services Intake Documents Intake Assessment- May be in EIS Intake Card Referral Documents (Including Pineland Center) Appeals Documents</p>	<p style="text-align: center;">5 years</p>	<p style="text-align: center;">Keep permanently</p>

2/3/2010

Funding Requests on Open Accounts

Funding requests for funds from open accounts may originate from the consumer or from some other member of the consumer's planning team; further, such requests may be directed at a broad spectrum of services and purchases. In all cases, however, they must meet these criteria.

First, they must be directed at an overall goal of increased independence, capacity building, or a therapeutic goal. These goals must be identified in the Person Centered Plan, or in some other supporting document.

Second, they must either be directed at a health or safety concern, clearly identified; or, in the case of recreational and social goals, they must be integrated into the plan in some fashion. For example, a consumer may request funding supports for a person to go on an excursion or a vacation. However, approval of funds for such purposes will be predicated upon the consumer's involvement in saving for or otherwise contributing to the achievement of the goal-in other words, approval is based upon the activity having some habilitative or learning value.

Third, supervisors must in all cases review and approve requests. Supervisors will prioritize requests, depending upon the funds remaining available in the accounts.

Inter-Regional Placement Procedure

When placement is being pursued in another region, the following procedure should be followed.

I. Placement Need is Identified

- A. Sending Resource Coordinator will contact receiving Resource Coordinators in other regions and will provide them with appropriate referral information regarding the identified consumer and intended placement via e-mail. Referral information is supplied by the sending ISC/CCM. Sending RC confirms MaineCare eligibility and Waiver status.**
- B. Receiving Resource Coordinator will send out Formal Referral/Vendor Call (based on referral information provided by the ISC/CCM) to all qualified vendors in receiving region via e-mail.**

- C. Interested vendors will contact the sending ISC/CCM via e-mail to collect more information about identified consumer and present placement options.**
- D. Once an appropriate opening is identified, the sending CM, in cooperation with the designated person will arrange a visit to potential placement site. Residential movement sheet may be completed.
- E. Sending **Resource Coordinator** assures that receiving Resource Coordinator is aware of ~~trial~~ visit and/or placement if/when it occurs.
- F. The persons team will determine the need for a pre-placement meeting and will arrange if needed.
- G. Sending Resource Coordinator completes EIS authorization, after consultation with receiving Resource coordinator, prior to placement.**

II. Placement The sending and receiving supervisor will negotiate case responsibility at the time of placement. The sending CM usually maintains case responsibility for 30 days or as negotiated.

- A. The receiving supervisor, with consultation from the sending CM or supervisor, will determine the need for a post-placement planning meeting.
- B. In those instances where a post placement meeting is deemed unnecessary, a case conference, consisting of the sending and receiving CMs, the consumer and the home operator, will be held. The purpose of the case conference is to review the consumer's program and service needs and assign responsibility to the appropriate individual.
- C. The receiving CM will assume responsibility for setting up the appropriate meeting forum. If a post-placement meeting is to be held, it will be chaired by the receiving region.

III. Transfer of Information The following information will be transferred at the time of placement.

- 1. Psychological
- 2. Residential movement sheet (to both CM and home operator), (optional)
- 3. Medical
- 4. Plan
- 5. Communication information (videotape of unusual signs, dictionary of communicative intent, instructions for use and programming of augmentative communication devices).

The consumer file, including the following information, will be transferred, as per negotiations of sending and receiving CMs:

- 1. Transfer of the primary responsibility on EIS
- 2. Rep payee account
- 3. Other pertinent information

The waiver file is transferred with the client file. The sending ISC/CCM retrieves the waiver file from the sending RC at transfer time. The receiving ISC/CCM forwards the waiver file to the receiving RC.

The supervisor will assure that the record is complete prior to transfer.

Development of the IST

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1. Criteria: An IST will be developed whenever the person receiving services experiences any of the following incidents:
 - a. Admission into a state run crisis residential program or other respite home as a result of a crisis situation.
 - b. Admission to an inpatient psychiatric hospital.
 - c. Three restraints in a two week period
 - d. Becomes homeless. A person will be considered homeless when he/she cannot return to his/her present home, and does not have a support network or a plan in place for future timely residential services.

Other. "Other means that, upon review of a situation or a series of situations, a person's team recommends creation of an IST. Examples might include behavior or psychiatric concerns that do not meet criteria above, health concerns of the consumer or family members, etc.
2. When one or more of the above criteria occur for an individual the Individual Support Coordinator (ISC) will be notified and will coordinate the convening of the person's planning team within seven working days.
3. If the individual has been admitted to a state run crisis residence an assessment will be done at the crisis home. This assessment will include a review of the incident, observations made in the home, environment of the crisis location, and recommendations for future intervention and support.
4. The person's planning team will review the crisis incident and any documentation provided, such as hospital assessments, restraint information, resource development information. The planning team will then develop a written crisis intervention plan, and will identify IST members and their roles. This plan should be preventative in nature and should include guidance about future response to potential crisis situations.
5. The person's planning team will review the need for specific training and identify who is responsible with clear time frames.
6. The IST will report to the person's planning team at least annually, but can determine if more frequent review is needed. The I.S.T. will determine what type of communication and review process is necessary for its role. The planning team also will determine if and when the I.S.T. has completed its work and may be dissolved.
7. A member of the Crisis Team and the person's I.S.C. must be a part of the I.S.T. Whoever is designated, as the lead coordinator for the planning process will monitor the I.S.T. team. The Crisis Team will maintain 24 hour, ten day, and quarterly follow-up to individuals who have an active IST. It will provide written follow-up to the I.S.C. for distribution to the planning team as appropriate.

Developmental Services Grievance and Appeal Process Insert

The Department finalized a Decree compliant notice to go out with all substantive correspondence to class members and guardians of class members. This notice is in the form of a colored insert. This was printed and distributed to all regions in August. Starting in September of 2004, all regions have been including this notice in substantive correspondence. "Substantive correspondence" is notices relating to the personal planning process and all correspondence which denies services or otherwise impacts the

rights of persons with mental retardation served by the Department². In order to fully incorporate this practice the Department will finalize a distribution protocol for all PCP coordinators (including agency PCP coordinators) and **add a section to the Case Management Manual regarding the inclusion of the insert into all substantive correspondence. As of 1/31/2005 we have not completed the added language to the CMM; however the other language changes have been drafted into the PCP Preparation and Procedure Guide and the PCP Protocol.** This will be made available to Plaintiff's counsel and the Master by January 31, 2005.

Mortuary Trusts

When individual consumers have assets that may offset their eligibility or continued eligibility for SSI and/or Medicaid Benefits it may be appropriate and prudent to consider a Pre-arranged and Pre-financed funeral arrangement, better known as a (Mortuary Trust Fund), as a means of protecting those assets. As these assets are considered to be assets of the Trust not the individual they are protected when qualifying for SSI and/or Medicaid.

A Mortuary Trust Agreement is an irrevocable written agreement between an individual or their guardian, the (Donor), and a Funeral Home which becomes the TRUSTEE for that trust, that authorizes the funeral home to establish an interest bearing account to cover the costs of funeral services upon the death of the individual named as recipient of the trust. All funds received by the Funeral Home and all interest that accumulates in the account can only be withdrawn upon the death of the individual named by the trust.

Depending on the specific circumstances, such as the age and health of the individual, \$1,400 to \$2,000 would be a reasonable amount to set aside in a Mortuary Trust and may be endowed either as a single deposit or on installments.

The following procedure is suggested when establishing a Mortuary Trust Fund:

1. Where appropriate, potential arrangements should be discussed with the individual and his/her family members and their wishes should be incorporated into the plan. This should include choice of funeral home, burial site and type of service.
2. Contact the funeral home to develop the specific Trust agreement that should include a clause requiring the home to advise the individual of the discontinuation of the trust or transfer to a different Funeral Home.
3. The Trust Agreement needs to contain at least the following provisions:
 - a. That the Trust is irrevocable.
 - b. The specific services to be provided.
 - c. The name of the Financial Institution where the proceeds and interest of Trust will be maintained.

² The Decree requires notice of the grievance and appeals process in the following instances: when a person's rights may be "limited or abridged" (Section VII(10)(h)); any "action or inaction by the defendants related to or involving rights afforded by, or arising under, this [decree]" (Section XII(1)); and in "notices relating to the personal planning process and to the provision of, or failure to provide, services" (Section XII(2)).

Personal Planning Policy

- A. Case Managers will plan with individuals for the coordination and delivery of supportive and other services through the development of a personal plan. The type of plan, participants and agenda at the planning meeting will be selected by the individual and /or their guardian.
- B. The personal planning process will be:
 - a. Understandable and in plain language or if the individual is deaf, non verbal, signing, or speaks another language; the process will include qualified interpreters.
 - b. Focused on the person's choice
 - c. reflective of and supportive of the person's goals and aspirations
 - d. Developed at the direction of the consumer and include people the consumer chooses
 - e. Flexible enough to change as new opportunities arise
 - f. Reviewed according to a specified schedule and by a person designated for monitoring
 - g. Inclusive of the needs and desires of the person without respect to whether those desires are reasonably achievable or the needs are presently capable of being addressed
 - h. Inclusive of a provision for assuring each person's satisfaction with the quality of the plan and the supports he/she receives
- C. The plan will focus on the supports identified by the individual.
- D. The plan will be received by the CM within thirty (30) days of the meeting date and needed follow-up will be implemented as outlined in the personal planning protocol
- E. The plan may be facilitated by the consumer, a case manager, other agencies providing major services to the individual, family members or other persons chosen by the consumer.
- F. The planning team will always develop a service plan or actions plan which outlines the agreements reached by the team. If a need listed on the service plan or action plan is not achieved by the end of the first quarter (90 days) it will be listed as an unmet need on the EIS

Personal Planning Protocol

The following protocol will be applied as practice in each Regional Office. It is expected that the Team Leaders will insure that this protocol is followed and that each CM is trained in the process. This protocol will be included in orientation for all new staff in the Regional Office.

1. The Regional Office will maintain an annual schedule of all planning dates. This schedule will be reviewed quarterly to insure that the planning dates are equally distributed throughout the year.
2. Each Regional Office will maintain a centralized tracking form (see attached sample) that includes: consumer name, CM, date of last PCP, date of current PCP, date CM received the PCP, QA review date, date plan submitted to C.O., Facilitator's name and status of report (i.e. rejected, accepted etc.). All follow up activities will be tracked with dates and actions taken.
3. The CM will receive the plan within 30 days of the meeting date. The CM is responsible for tracking the 30 day period. When received, CM will complete an initial review of the plan for accuracy and review appropriate data on the MIS. The CM will attach the QA sheet and MIS and submit the plan for review.
4. Each Regional Office will develop a notification system to be implemented when a plan is overdue.
5. The PCP review team will review the plan within 14 days of the receipt by the CM.

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6. The review team will submit PCP for signature to the Developmental Services Team Leader the same day they are reviewed and are accepted.
7. The PCPs will be signed by the Developmental Services Team Leader within 10 days of receipt. The original is to be returned to the community agency or home. The distribution will be completed within 7 days of receipt.
8. PCPs that need revision or an addendum in order to be approved are to be returned by the review team to the CM on the same day they are reviewed. PCPs needing revision or an addendum will be returned to the review team within 14 days. (Minor revisions can be done by the CM via phone call with appropriate team members.) The plan facilitator will be responsible for more substantial revisions and agency and DHHS personnel shall maintain the time frames established in the personal planning protocol. The CM is responsible for tracking the 14 day period.
9. The Team Leaders and Regional Supervisors are responsible for the tracking form. A plan for training and follow up of plans that indicate repeated rejections will be developed with agencies and/or CMs. Compliance with time frames set out by this protocol will be incorporated into annual performance evaluations of CMs, Regional Supervisors, and Team Leaders. Service Agreement and Contracts with agencies will include PCP protocols as a Performance Indicator.
10. The CM will insure that private/sensitive issues that need to be discussed outside of the planning meeting are addressed. Information on these issues will be reflected in the MIS when appropriate.
11. All newly hired CMs will be provided introductory training on the PCP process within 30 days and comprehensive training within 90 days of hire.

Protocol for the Provision of Case Management Services for People who do not Receive Mainecare Services

10/17/2008

Purpose- this protocol is to provide guidance for Regional Offices who receive a request to provide case management services for people who are not Mainecare eligible but have been found eligible for Developmental Services. The following guidelines will be utilized in deciding when and what type of services will be provided:

1. According to 34-B 5201-6 as well as Mainecare rule case management is an entitlement only for Mainecare recipients. During the intake process this procedure should be shared with individuals who are not eligible for Mainecare.
2. The following should be considered when determining the assignment of case management services to a person who is not Mainecare eligible. The Supervisor of the Regional Office makes the determination:
 - a. Is the person in an adult protective situation where the assignment of a case manager is necessary to assure health and safety?
 - b. Does the person need a public guardian?
 - c. Has the person been denied Mainecare as a result of benefits being too high (ex. SSDI)? If the person is found eligible for section 21 or 29 will this make the person eligible for Mainecare? If this appears to be the case the following steps can be taken:
 - i. If the person has identified a community case management agency and they are willing to accept the person and assist them with the processes involved in

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becoming Mainecare eligible understanding they can not bill for any service provided until they are eligible a referral can occur.

- ii. A state case manager can be assigned to assist the person to become Mainecare eligible and then a decision can be made by the consumer regarding future case management.

c. Upon review by the Supervisor it is felt that an assignment of case management to assist the person to connect to available resources/needs is beneficial to the person and that there are resources available in the office to provide that service maintain the standard set in law, policy, and oversight. The Supervisor has the right to time limit this service.

Protocol for Use of Home Visit Tool

Purpose:

The Home Visit Tool has been developed through a collaborative effort between the Office of Quality Improvement (QI) and representatives from the Office of Adult with Cognitive and Physical Disabilities (Developmental Services) including the Quality Assurance Team. The tool has been designed to collect information from case managers during home visits made with consumers living in non-licensed homes. As we continue to assess current practices in efforts to establish standards, the Home Visit Tool enables case managers to report findings through documentation review, consumer input, and observations in areas regarded as factors of good practice and effective service delivery.

It is the practice of Developmental Services Case Management as well as requirement under Mainecare to assure that the services provided to Mainecare recipients in home supports meet the requirements outlined in the person centered plan. Home visits are one avenue to meet this case management requirement. It is also intended as a tool to generally improve the assessment capability of case managers as well as serves to aid supervisory contacts specific to home visits.

Samples:

This tool is being added to a variety of existing quality assurance activities within the system including monthly case management contacts, home visits, and annual person centered planning.

This tool will be completed for consumers meeting any of the following criteria:

1. Beginning in January of 2009 all people living in non-licensed 24 hour support homes will be reviewed within a 3 year period using the Home Visit Tool. Sample selections will be provided by the Office of Quality Improvement on a quarterly basis. Names will be received by Team Leaders for distribution. Case managers are responsible for completing the tool, reviewing this with supervisors and providing a copy to Quality Assurance Team Representative for tracking purposes before the close of the quarter.
2. Additionally, it is the expectation that case managers will visit the new home any person changing residency and complete a Home Visit Tool within third and sixth months of the person moving into a new home regardless of whether it is licensed or unlicensed. Case managers will review completed tools timely with assigned supervisors and will also submit copies of forms to QA team member.

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3. Also, the Home Visit Review Tool can be utilized by the Case Management System when there are concerns regarding residential supports, including consumer health and safety and quality of services provided (e.g. staffing allocation, unmet needs, good practice etc). The decision to use the tool should occur between the case manager and Supervisor. If the concerns rise to a level where a review and documentation are deemed necessary then the use of this tool is recommended.

Home Visit Review Process

The Home Visit Review process should be viewed as a collaborative effort between staff working within the case management system at various levels (including the case manager, supervisors, team leaders and other Developmental Service central office staff).

The following processes will occur:

- a. QI will provide the names of people living in non-licensed homes with 24 hour support who need a review using the Home visit Tool within the first week of each quarter. These names will be sent to the Team Leader in each region for distribution. However, for consumers who are changing residency and/or in cases where there is concern(s) around health, safety or services, individual names will not be provided to staff by QI. It is the responsibility of the case manager and supervisor to identify these individuals and complete Home Visit Tools. All Home Visit Tools are to be reviewed between the case manager and supervisor.
- b. It is the shared responsibility of the Team Leader to assure the assignment of review and completion of the tool. The process of assuring this may differ regionally; Team Leaders may determine the most efficient manner to track reviews. QI will inform Team Leaders of delinquent submissions quarterly.
- c. Case Management Supervisor in working with the case manager will decide the response to any concerns and to document these responses on the tool. This can include:
 - i. The case manager addressing issue with the home
 - ii. The Supervisor addressing issues with the home or administration
 - iii. The Supervisor requesting review and assistance from quality assurance.
 - iv. The Supervisor bringing concerns to the Team Leader and Management Team.Progress of these resolutions is to be documented in Action Notes.
- d. A copy of the review will be maintained by the Case Manager, Supervisor, and the original copy will be forwarded to the Quality Assurance Manager in the Region.
- e. QI will provide oversight to the Home Review Process by providing sample requests and collaborating with central office staff around outstanding reviews as well as issues/concerns identified through Home Visit Review Tools.

Instructions:

The Home Visit Tool Does Not replace or substitute for an Action Note. The action note should include all necessary elements for billings as well as reflect a summary of the consumer status and summary of the visit including any findings. Case managers are to use EIS action notes to document any resolutions or follow-up to this home visit.

- Page (1) asks for key information about the consumer and relevant materials the case manager may review in preparation of the visit. Fill in information about the consumer as well as the date of the review and answer questions 1-6. It is suggested that case managers periodically review information to assure that other data systems (EIS) reflect accurate up to date information. Indicate policies that have been reviewed either through evidence of the providers' policy manual or discussion with provider staff that such policies exist and there is an understanding of the policy and it is implemented.

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- Pages 2-4 identify areas to consider during the home visit. This includes a consumer status and interview portion of the tool and sections to document around the physical site and provider record.
 - Case managers are instructed to check the appropriate column if they, in fact, assessed for the specific item using, but not limiting their assessment to, guidelines included on the form. Do Not write 'yes' or 'no', or 'not applicable'. A mark in the column indicates the case manager assessed the specific area. If an area was not considered at the time of the home visit, Leave the column BLANK.
 - Guidelines do not denote set standards, however, these provide points to consider when assessing for consumer health, safety, and good practice while looking over conditions at the home and reviewing the written record. While assessing around health, safety and good practice case managers should also take into account the requirements outlined in MaineCare standards and under the Waiver.
 - Case managers are to document any concern or issue identified in the home or record or through the interview by checking the 'Additional Follow-Up' column and including a note in the comment section specific to the concern that will be reviewed with the supervisor.
 - Similarly, the section identified 'Consumer Status' on page (3) of the tool assists case managers in assessing areas of the consumer's life through talking with the consumer directly. This section provides the case manager with prompts to explore 'domain areas', checking off as these areas have been assessed or discussed, if the consumer expressed overall satisfaction or dissatisfaction and areas warranting follow-up. A space is provided for documenting comments for each domain.
- The final page outlines a supervisory review of the tool, its findings and any planned follow-up for identified concerns or deficiencies. All Home Visit Tools are to be reviewed with the case management supervisor.
 - The supervisory review should be completed within reasonable timeframe with consideration given to the level of concern or deficiencies at the home. The time lapse between the visit and supervision should not exceed 14 days, regardless of issues or concerns identified.

Any concerns documented in previous pages are to be outlined in this section and include steps/actions to address concerns. Case managers are to track progress of resolutions through action notes.

Ratio Policy

Case Management Ratios for

Purpose and Scope

Case Management Services is provided through Developmental Services as well as Community Case Management. It is required that the regional offices and provider offices maintain an over-all ration of 35-1 in order to meet the requirements of the Community Consent Decree. It is also required that for those individuals who meet the eligibility requirements for Developmental Services (34-B M.R.S.A.) and are identified as needing case management services that those services be provided within a 90 day time frame. The purpose of this policy is to identify how this system will function in order to provide services and meet the requirements.

Procedures

The option for case management services through Developmental Services case management system for the population identified as eligible for community case management will only be offered if the over-all ratio is below 32-1 in the regional office (Portland, Lewiston, Augusta, Thomaston, Bangor, Presque Isle). This is in order to respond to the need for guardianship or adult protective situations and to still maintain a 35-1 ration.

Release of Information

I. Purpose

The purpose of this information is to insure the confidentiality of all written records or accounts in accordance with state and federal statutes and regulations. An effective confidentiality procedure should result in the protection of the dignity and privacy, rights and interest of the individual client and his/her family. As a general principle, the client person and his/her legal representative has the right to decide what personal information may be released, to whom and for what purpose. Generally, a person requesting information should demonstrate clearly that the requested information will serve a specific purpose associated with the needs of the client. Case managers should refer to their regional office for a copy of the Maine State law on Disclosure of Client Information.

II. Obtaining Information From Another agency or Individual

There must be a release of information form, signed by the client, if legally competent, or the client's legal guardian, in order to obtain information about the client. In obtaining information from another agency or individual, inquiry should be made as to the agency/individual policy regarding release of information. The agency/individual policy should be honored insofar as possible in DHHS utilization of the information.

III. Release of Information to Another Agency or Individual

There must be a release of information form, signed by the client, if legally competent, or by the client's legal guardian, in order to release any information about the client. In releasing information, the DHHS worker must make sure that the information is stamped as being privileged and confidential. The release of information shall specify the information released. There must also be a clear notation in the case record indicating the information released and the circumstances of the release.

IV. Client/Legally Authorized Party Access

A. General: Clients, former clients, or other legally authorized parties may examine the entire client record, if the request is submitted to the regional office/facility. In order to avoid misinterpretation of record content, a professional staff person should be available to answer questions at the time of the record review. The client or legally authorized party may obtain copies of any or all parts of the record and may be charged a reasonable cost for such reproduction.

B. Exceptions: There may be situations where information contained in the client's record may be deemed by a professional as harmful to the client or his/her family. Discretion shall be used in the disclosure of this type of information. Discretion must also be used in releasing information regarding an adult protective investigation, e.g., 22 MR Section 3474 subsection 2, Optional Disclosure of Records.

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V. Family Relative Friends (other than legally authorized party) Access

When a client or legally authorized party gives written consent to have specific record or type of record released to a specific person on a routine basis, such information shall be released routinely.

VI. Emergency Treatment

In emergency situations, information about the client may be released without a signed release of information in order to secure the emergency treatment needed, e.g., medical emergency, emergency placement.

VII. Transfer of Information within the Department

The transfer of client information interdepartmentally within DHHS may occur when a) there is a clear need for the information transfer; b) the case record is properly noted regarding the transfer; and c) the material is clearly marked confidential. No release is needed.

VIII. Agencies and Individuals Serving Developmental Services Clients

An individual or an agency should be permitted access to client files in the absence of either the client's informed written consent or a court order, only to the extent that disclosure of information is "necessary to carry out any of the statutory functions of the department", 34B MRSA, Section 1207, subsection 1B. If the individual or agency is, by contract or other agreement, performing a function on behalf of Developmental Services for its clients, access to whatever information is needed to carry out that function should be granted. Some statutory functions of DHHS are specified in Maine law: assessment of need to develop a prescriptive program plan, 34 B MRSA Section 5462; execution and performance of service agreements, subsection 5471; provision of protective and support services, Section 5203; provision of residential, educational training services to wards of DHHS, 18 MRSA subsection 3628. The range of services which are required to fulfill DHHS's obligations will vary from client to client and from case to case, as will the scope of disclosure which is necessary to carry out those obligations. Individuals and agencies seeking access to files in the control of DHHS, as a threshold, must be working on behalf of the at the request of DHHS.

IX. Court Order

An order of the court shall cause the institution/regional office to disclose information to the extent required by the order. A copy of any such legal order shall be kept on file in the client's record. Any question regarding the validity or interpretation of the court order shall be referred to the Attorney General's Office for resolution.

X. Education/Research

Permission may be given for students or researchers to view specific types of information, based on a written request. Approval may be given by the Program Manager for Developmental Services.

XI. Assessing Ability to Give Informed Consent

There will be situations where a client's ability to give informed consent may be in question. A psychologist an advocate and interpreter, if needed; should participate in any assessment of a client's ability to give informed consent.

XII. Confidentiality with Legislators

From time to time legislators become involved with individual client situations and will ask for information. In these cases, the same release of information provisions would apply to a legislator, as to any person seeking client information. Department statutes set out these circumstances under which information can be released. These are:

1. with consent of the client or legal guardian,
2. as necessary to carry out the functions of the Department,
3. by Court order.

As with any person, an explanation of our confidentiality statutes and the importance of protecting the privacy of clients should be given. It is also important to offer to assist the legislator in obtaining necessary releases.

XIII. Questions

You should always seek the advice of other experienced caseworkers or your supervisor whenever there is any question about confidentiality. Caseworkers and supervisors should also not hesitate to consult the Attorney General's office and ask for a legal opinion regarding confidentiality. The AAG's Office can be reached at (207-626-8800) TTY (207-626-8865).

Reportable Event Protocol for Developmental Services Office Coverage

Purpose-

The purpose of this procedure is to assure that there is a consistent process for reporting an event to a regional office per the reportable events policy. The regional offices are Portland, Lewiston, Augusta, Thomaston, Bangor, and Caribou.

Procedure

1. Each regional office will have an office coverage process in place that allows for I.S.C. level of staff or above to be available to take a reportable event phone call
2. When a reportable event that must be called in IMMEDIATELY is called into the regional office (see reportable events form and policy) the phone call will be forwarded **live** to the office coverage person. A call back to the person is not acceptable.
3. When a report is called in by a non- provider (i.e. family, friend, community member) all portions of the reportable events form should be filled out by the office coverage person.
4. When a reportable event is called into the regional office by a provider agency with information about an event that must be reported IMMEDIATELY the office coverage person should fill out the **Reportable Events-Developmental Services Office** form. This is the reportable events form with areas highlighted that needs to be filled in for the initial call. Any further information that is gathered should be entered as well. **Providers should be informed that they need to submit the reportable events form by fax or mail within 2 business days of the event.**
5. The office coverage person will immediately give this form to the Incident Data Specialist. **It is the responsibility of the office coverage person to assure that the IDS (or the person covering) is aware of the incident as soon as possible. This cannot be done by voice mail or e-mail. Incidents that are**

immediate in nature are being reported through the IDS and it is their responsibility to assure that people who need the information get it as soon as possible.

6. **The IDS will follow the reportable events policy for logging the report and informing the appropriate offices or people.**

The office coverage person should not accept calls for reportable events not required to be reported **Immediately (i.e. restraint, med. errors, licensing)**. Agency staff should be informed that they need to fill out the Reportable Events form and fax or mail it within one business day of the event. Office coverage staff should make sure that the event is NOT an event which is required to be reported immediately, for example a med error which ordinarily does not require immediate reporting, which results in a severe adverse reaction, should be reported immediately.

Residential Move Planning

I. Introduction

Case Managers are frequently responsible for the coordination of residential movement. The consumer may directly request assistance or the move may be indicated through the consumer's planning process. Any residential change requires sensitivity to the consumer's understanding of what has been decided and how the move will occur. This would include planning for the preparation of the consumer, transition, and follow up contact after the move is accomplished.

Each move is unique and requires individualized coordination and monitoring. The following sections in the manual provide some assistance by way of a checklist, residential movement form, and guidelines for emergency residential movement. The Case Manager, in consultation with the consumer, support team, and supervisor; will develop a movement plan in the consumer's Best interests. It is not mandatory to use all or any of the specific checklists and forms provided.

II. Residential Movement Sheets

Each time a consumer is moved, the Residential Movement Sheet may be completed and/or updated and should accompany the consumer to the new residence. The purpose of this form is to assure that the new residence has up-to-date and accurate information regarding the day-to-day needs of the consumer, i.e., medication, ADL needs, and behavioral considerations.

III. Procedure

1. Prior to the consumer's move, the CM, completes the Residential Movement Sheet.
2. Please note on page 1, the section covering behavior problems (briefly describe). If remarks are made in this column, specific details should be given to the provider and/or page 5 Section VIII completed. If the consumer does not have behavioral difficulties, page 5 may be left blank.
3. One copy should accompany the consumer when placed in the new residence.
4. One copy should be maintained in the consumer's case record.

Residential Movement Sheet

Page 1.

Residential Movement Sheet

NAME: _____

BENEFITS

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RECEIVED: _____

SEX: _____

GUARDIAN: _____

REP. PAYEE: _____

DOB: _____

MEDICARE #: _____

TEL: _____

MEDICAID #: _____

SS # _____

MOVING FROM: _____
(include phone #)

MOVING TO: _____

HOW LONG AT ABOVE ADDRESS: _____

DATE OF MOVE: _____

CM INVOLVED: _____

CM INVOLVED: _____

PROGRAM/JOB: _____

PROJECTED PROGRAM/JOB: _____

REASON FOR MOVE: _____

I. MOST RECENT DIAGNOSIS: _____ DATE OF MOST RECENT PLAN: (include Plan) _____
CRITICAL AREAS REQUIRED IMMEDIATE ATTENTION

A. FAMILY PHYSICIAN: _____ TEL: _____ 1. MEDICAL PROBLEMS (describe briefly)

B. MEDICATION:

C. ALLERGIES:

2. BEHAVIORAL PROBLEMS (describe briefly)

D. SEIZURES:

E. DIET: SPECIAL CONSIDERATION:

II. PHYSICIAN/SENSORY HANDICAPS

III. ADAPTIVE EQUIPMENT

NORMAL

A. VISION _____

B. HEARING _____

C. AMBULATION _____

IMPAIRED

A. HEARING AID _____

B. GLASSES _____

C. BRACES _____

D. SPLINTS _____

E. WALKER _____

F. WHEELCHAIR _____

D. COMMUNICATION

VERBAL

SIGNING

AUGMENTATIVE/ COMMUNICATION DEVICE

GESTURES

EXPRESSIVE/RECEPTIVE

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IV. DAILY LIVING SKILLS: (make a (x) after each statement that accurately describes the applicant's situation)

A. EATING

1. Utensils: Spoon ___ Fork ___ Knife ___ Adaptive Equipment ___

2. Skills:

Needs to be fed _____

served _____

Supervised (choking) _____

Able to serve self appropriately and eat a "normal" pace _____

Case Management Manual

- Able to participate in food preparation _____
- b. Toileting**
1. Incontinent of bowel and bladder _____
 2. Incontinent of bladder only _____
 3. Occasional accidents _____
 4. Wears diapers, if so when _____
 5. Schedule training _____
 6. Will indicate toilet needs to staff _____
 7. Uses the bathroom independently; needs refinement _____
 8. Attends to toileting needs independently including washing hands _____
- C. Dressing**
1. Requires hand over hand assistance _____
 2. Able to undress _____
 3. Able to put on articles of clothing, but requires staff prompting and assistance _____
 4. Staff assistance necessary for buttoning, tying, zipping, etc _____
 5. Dresses independently, needs staff assistance for appropriate clothes selection _____
 6. Selects coordinated outfits including outerwear appropriate for the weather _____

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- D. Washing/Bathing**
1. Needs hand over hand staff assistance _____
 2. Washes incompletely, requires staff direction to wash all areas _____
 3. Staff needs to provide verbal prompts and guidance; give soap and washcloth _____
 4. Is able to draw water, but consumer can bathe independently _____
 5. Able to carry out bathing, drying, etc. independently _____
- E. Hair care**
1. Requires staff to wash, rinse, and comb/brush hair _____
 2. Needs help in applying shampoo and rinsing; requires only "touch-up" combing _____
 3. Is able to wash and rinse hair with verbal prompts only; brushes independently _____
 4. Independently in all areas of hair care _____
- F. Tooth brushing**
1. Needs to have teeth brushed by staff _____
 2. Hands-over-hand assistance is required in tooth brushing _____
 3. Applies toothpaste, but requires staff to cues to brush thoroughly _____
 4. Applies toothpaste and brushes teeth completely independently _____
- G. Sleeping**
1. Wakes frequently during the night _____
 2. Has nightmares _____
 3. May get up and wander during the night _____
 4. Wakes rarely or occasionally to use the bathroom _____
 5. Sleeps throughout the night _____

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V. SOCIAL SKILLS

1. Interacts with staff only _____
2. Interacts with peers _____
3. Enjoys social activity _____
4. Enjoys going out into the community _____
5. Dislikes being around groups of people, crowds _____

VI. MISCELLANEOUS

- | | YES | NO |
|--|-------|-------|
| 1. Able to follow simple directions | _____ | _____ |
| 2. Able to go outside and knows the way around | _____ | _____ |
| 3. Any difficulty in mobility (specify) | _____ | _____ |
| 4. Able to care for self during menstruation | _____ | _____ |
| 5. Awareness of time in relation to daily activities | _____ | _____ |

VII. PERSONAL IDENTIFYING INFORMATION

INTERESTED AND INVOLVED FAMILY/OTHERS _____

RELIGIOUS PREFERENCE _____

LIKES/MOTIVATORS (Special activities, personal belongings, friends): _____

Case Management Manual

DISLIKES (activities, sensory stimulation, etc.): _____

Page 5.

VIII. PREVIOUS PLACEMENT INFORMATION

If placement has terminated due to problem behaviors, please answer the following:

Description of Behaviors(s) Issue (psychologist/family)	Duration of Behavior (6 mo/10yrs)	Frequency (once a day twice a wk)	Antecedents (events preceding)	Consequences (events following behavior)	Person Involved Resolving the
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1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

EXAMPLE:

Kicking other consumers with foot	2 years	Once a day	Someone changes T.V. station	Ask consumer to apologize, then leave room until calm	Boarding home operator
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Checklist for Moving a Consumer

	ACTION NEEDED	DATE COMPLETED
1.	Document plan recommendations or consumer request	_____

Case Management Manual

2.	If moving to another region, refer to Procedure for Inter-Regional placement.	
3.	Involve the correspondent/family and advocate in the decision-making process through the planning process. In emergencies, assure that notification occurs.	
4.	Coordinate support services as recommended by the plan.	
5.	Follow ICF/MR or Waiver application process if needed	
6.	Complete PASRR screening requirements if needed.	
7.	Send Special Education notification to the Special Education Director of the receiving district when the consumer is placed out of the natural home.	
8.	Arrange Pre-placement visit.	
9.	Arrange transportation and cancel current transportation.	
10.	Notify all agencies providing support services.	
11.	On or prior to moving day, have "placement packet" ready for the new home and/or program. This should include the Plan, Medical information, Psycho-social, and Psychological. Some regions include the Residential Movement form.	
12.	Update the EIS.	
13.	Update the waiver checklist, if needed.	
14.	Notify Social Security and/or regional Account Associate, if DHHS is the representative payee. Assist as appropriate with this notification, if there is another payee.	
15.	Notify DHS of address change for Food Stamps and Medicaid.	
16.	Notify Post Office of change of address if appropriate.	
17.	Notify Family/Correspondent of change of address after move.	
18.	Update photo ID information if applicable.	
19.	Arrange for utility disconnection and hook-up if applicable.	
20.	If the consumer has a private bank account, arrange for a transfer.	
21.	Assure the consumer has a means for obtaining personal spending money.	
22.	Review the need for notification of the crisis team.	
23.	Schedule a post placement meeting, if appropriate.	

Removal of a Person from a Residence

Following an investigation by an appropriate departmental group, including but not necessarily limited to Adult Protective Services, a recommendation will be made to a Case Management Supervisor as to whether an individual or several individuals should be removed from a particular residence. The recommendation will be reviewed by the Supervisor and the Developmental Services Team Leader who will consult as needed with the Director and the Developmental Services Program Manager. If the conclusion is reached to remove one or more individuals from a residence, the following steps will be taken:

1. The guardian shall be contacted and consent obtained
2. The individual(s) shall be contacted as appropriate
3. If protective action is involved, the Adult Protective Unit shall be contacted
4. Appropriate efforts shall be made to secure the concurrence of the individual and/or guardian and the Adult Protective Unit when appropriate. In emergency situations involving high probability of danger to one or more individuals, prompt action must be taken to ensure the safety of the individual(s) involved.
5. The decision shall be communicated to the owners or operators of the facility.

6. An appropriate plan shall be designed and implemented to remove the individual(s). This plans should include who and how many individuals will need to participate in assisting the individual to leave the residence. In rare situations this might require the presence of the police.
7. The Commissioner or designee shall be apprised of the removal and the issues leading to the action and the follow-up to the removal.
8. Appropriate licensing staff will be informed of the action.

Residential Placement of an Emergency Nature

There may be times when due to crisis circumstances that an emergency placement may be necessary. If this is due to behavioral health issues, generally the Crisis team in the region may be involved and assume the lead role in effecting emergency placement if the situation can not otherwise be stabilized. The protocols developed to guide the Crisis system will be utilized.

1. To communicate all pertinent medical behavioral information to the person(s) receiving the individual. All reasonable attempts should be made to deliver this information in writing so as to ensure clear directions for the receiving staff.
2. Specific and concrete plans to follow-up with the individual, the guardian or family and the receiving staff in order to:
 - A. Determine how the individual is adjusting
 - B. Delivers any necessary additional information
 - C. To develop and/or communicate plans for the future

The Case Manager (CM) will follow-up within 24 hours to ascertain the following:

1. How well the individual has adjusted
2. That the medical or behavioral information has been understood and followed
3. That there is clarity about the length of the emergency placement
4. That the individual's possessions and money are available to him or her
5. That the staff is aware of who to call and under what circumstances to call should any difficulties arise
6. That any necessary regulations involving placement are followed
7. Ability of staff to communicate with the individual in his/her preferred communication mode.

Retention of Minor Incidents Reported Directly to Case Management

This procedure is to clarify the retention of minor incident reports received directly to case managers for people with disabilities they support. These reports are outside the reporting requirements specified in the reportable events policy. (See reportable events policy under adult protection-
<http://www.maine.gov/dhhs/OACPDS/DS/APS/index.htm>)

It is not the policy of Developmental Services to require the retention of actual minor incidents reports outside of the reportable events system in the files of consumers. Incidents that occur in which the Case Manager feels the necessity to document that it occurred can do so through an action note referring to an

incident received with the responsibility for retaining the incident form resting with the provider who reported.

The case manager in unusual situations can determine that a copy of the incident be retained in the file, however this should not be the common practice.

Waiting List Management Protocol

September 24, 2003

Statement of Purpose:

Maine will have a consistent, fair and predictable method by which it manages the Developmental Services Waiver Waiting List.

Policy:

The Developmental Services Waiver program is a Medicaid (known in Maine as “MaineCare”) service. Individuals must be found to be financially eligible for MaineCare, medically eligible for these services, and eligible because there is an available slot. Eligibility for persons to receive Developmental Services Waiver services shall be prioritized on the basis of the individuals’ needs. The Department of Behavioral and Developmental Services’ Enterprise Information System (EIS) will identify individuals on the waiting list and their needs

Routine Practice:

1. Individuals found financially and medically eligible for Developmental Services Waiver services, will be allowed to apply for services.
2. The intake worker will enter the application information on the EIS.
3. As support recommendations for consumers already receiving case management services are identified, the assigned Case Manager will enter the information on the EIS.4. If there is a slot available, eligible individuals will be assigned a slot. If a slot is not available, the individuals will be asked whether they want to be placed on a waiting list. Individuals, who want to, will be placed on the waiting list.
4. In order to keep information current and consumers and families informed, the Regional Office will:
 - a. For individuals receiving case management services through the Regional Office: keep the data in the EIS current in relationship to changing needs;
 - b. For individuals not receiving case management services through the Regional Office: contact consumers and/or families via mail, at least annually, to request updated information relative to previously identified needs;
 - c. Continue to review its current budget and other resources regarding the availability of funding for the services requested;
 - d. Review waiting list information generated by the EIS in each Region on a monthly basis and prepare information for the Central Office at the time of budget submission.

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Routine Implementation Priorities:

Individuals on waiting lists shall be given a slot as slots become available based on the following three (3) categories of priority (Priority #1 is the top priority):

1. Priority #1: By statute 22 MRSA §3473, the Department is required to provide adult protective services to persons with mental retardation who are faced with abuse, neglect, exploitation or the substantial risk of abuse, neglect or exploitation. The Department is required to respond to such situations immediately in order to assure the health and safety of the individuals. Accordingly, a certain number of slots must be reserved and available for these individuals. Historically, for the fiscal years ending June 30, 2000, 2001 and 2002 the average number of slots utilized for these Priority 1 individuals was 120. However, for any given year, the number of slots may vary, and the Department may need a greater number of slots for these Priority 1 individuals.
2. Priority #2 includes individuals whose needs if not addressed within the specified time period, the potential will exist for the consumer to be in a situation with risk of physical or emotional harm or significant regression. Examples are as follows:
 - a. School-aged individuals receiving residential support and needing that support to continue,
 - b. Individuals currently placed outside the state of Maine who can be better served in Maine,
 - c. Adults who will graduate (or who have graduated previously) from high school have no continued supports,
 - d. Individuals living with a family or direct support professional(s) who may no longer be able to continue in that capacity
 - e. An individual whose medical or behavioral needs are creating stress on the family or current living situation,
 - f. An individual at risk of involvement with the criminal justice system,
 - g. An individual living with a family or direct support professional(s) who must work to maintain the household and who would be unable to work if some support services are not provided,
 - h. An individual living in unsafe or unhealthy circumstances
 - I. An individual ready to leave a psychiatric hospital, acute care facility, nursing home, shelter or jail and who would be unable to live in the community without services.
3. Priority #3 includes individuals whose needs do not place him or her at risk of physical or emotional harm or regression. An example is as follows:
 - a. Individuals wishing to move but are unable to do so under any other state or MaineCare program.

In the situation whereby a child and an adult have concurrently requested Home & Community-Based Waiver Services and both are being considered for a single slot³, the following process shall be utilized in order to make a final determination on which individual will be prioritized to get Developmental Services waiver services.

- Individuals must be identified as meeting Priority #2 criteria of the Waiting List Management Protocol.
- The Program Director of Developmental Services (Jane Gallivan) and the Director of Children's Services (Joan Smyrski) will review all submitted documentation, and as necessary request a case presentation by the DHHS regional staff involved to assure that they are fully informed.
- Case presentations will include such information as, the individual's current status and needs, a clear description of urgency in the case, and health & safety concerns.

Case Management Manual

- Clinical consultation shall be provided by DHHS Medical Director (s) if consensus between the Program Directors is not reached.
- Final determination of who shall received priority for a slot shall be reached within 10 working days of the initial request.

Critical Incident Reporting will also occur through the reportable events system. The IDS will notify the appropriate people of any event that is reported that meets the criteria of a Critical Event.

Section V Medical

Medical Services

It is the Case Manager's responsibility to monitor the consumer's access to medical and dental services. For consumers who live with their families, the Case Manager may need to assist the family in locating a physician or dentist. Generally, the family will assume responsibility for making appointments and providing transportation.

A licensed residential provider has an obligation to assure that the consumer receives medical and dental services. The Case Manager should only assume this responsibility as a last resort, or in situations where the Case Manager has questions or concerns to relay to the physician or dentist.

The Case Manager needs to maintain records, copies of reports, etc. regarding the consumer's medical condition. The Case Manager needs to know who the primary physician is, and the status of any acute or chronic medical problems. The Case Manager communicates this information to persons involved with the consumer who "need to know" the consumer's medical condition.

For most consumers, either Medicaid or Medicare will reimburse medical expenses. Certain medical services and supplies can only be received with prior authorization from the Division of Medical Claims Review, Department of Human Services (289-3081). Rules covering medical services and reimbursement can be located in the Maine Medical Assistance Manual.

Dental services are generally not reimbursable, except for children.

Audiology

An audiologist can identify hearing problems and helps in remedying these problems. A baseline hearing exam should be performed for individuals upon turning 55 years old and every 5 years thereafter, unless the audiologist has a specific reason to recommend a more frequent examination. Case managers should consider a referral if any of the following is present:

- frequent ear infections or upper respiratory disease,
- significant delay in speech and language,
- history indicating risk for hearing impairment.

Communication Therapy Referrals

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Speech, language and communication specialists work with individuals encountering difficulty in verbal communication. This discipline works to verify possible language disorders, to describe language abilities and disabilities, to identify factors, which may effect remediation, and to plan remediation programs.

In the case of deaf, hard-of-hearing or hearing nonverbal individuals who use any signs or gestures referred for a communication evaluation, ask specifically for the specialist's knowledge of sign and gestural systems and ability to evaluate.

For further assistance in obtaining a sign language evaluation, ask the Departments Office of Deaf Services or the designated signing caseworker in the regional office.

Refer when:

1. There is an apparent discrepancy between what the consumer has to say and his/her ability to say it.
2. Consumer has no functional communication system.
3. There is a question concerning need for an alternate/supplemental communication system (e.g., signing or communication board).
4. Speech is generally unintelligible.
5. There is a noticeable loss of communication skills.
6. Consumer's "use" of language is not appropriate or functional for communication.
7. You suspect a hearing loss.

Dealing with Physicians

The medical profession has historically played an important role in the early diagnosis of mental retardation and related developmental disabilities. In recent years, research has greatly expanded our knowledge as to the myriad causes of mental retardation. Advances in the field of genetics have allowed the medical profession to extend its diagnostic capabilities into the prenatal period.

In most cases, the physician is the first professional consulted by a family when developmental problems are suspected during childhood. As regular postnatal care becomes more routine in our society, we can expect that developmental problems will increasingly be identified during the early stages of growth. In many cases, physicians will be in the position of confirming problems already suspected by parents. In other instances, the physician may detect developmental problems before the child's parents have become aware of them.

Our society ascribes high status and great authority to the physician. As such, the content of the physician's informing interview with the parents of a child with a developmental delay can affect treatment of the child for years to come. Many parents have sought institutional placement for their children with disabilities based on their physician's advice. Others have delayed seeking assistance because they were told that their child would "grow out of it".

It is very important that the Case Manager develop a positive, collaborative relationship with the consumer's physician. The Case Manager should keep the physician informed of his/her activities surrounding the consumer and attempt to involve the physician in the developmental assessment.

Case Management Manual

The Physician's knowledge and perception of the individual are important components in a comprehensive assessment and every effort to include the physician as an active team member should be made. This is particularly true in the case of consumers with severe and multiple handicaps. Seizure control, orthopedic needs, and medical stabilization rest squarely with the physician. Often, active treatment and programming cannot begin until these needs are met.

The medical profession has professional boundaries which are clearly defined and closely guarded. The Case Manager must be sensitive to this dynamic in order to foster a productive working relationship. In consulting with a consumer's physician, the Case Manager should avoid diagnosing the consumer or recommending specific modes of treatment. In essence, problem identification is best done in descriptive rather than analytical terms.

Case management with medically needy, developmentally delayed consumers will be easier and more productive with the active and informed cooperation of the physician. As such, advocacy in the area of medical care should be balanced by an awareness of, and sensitivity to, the unique nature of the physician's relationship to the consumer. The Case Manager should seek to share with the physician the total picture of the consumer's assets and needs that is gained from the case management perspective. In doing so, the Case Manager can assist the physician to coordinate his or her activities with the overall treatment plan for the consumer.

Dental Services

Medicaid will not reimburse dental services for adults, a person's access to community dental services may be constrained by financial resources. Case Managers are encouraged to pursue dental services within their social community prior to approaching the Department funded Dental Clinic.

Dental services are provided at the Dental Clinic and at various outreach sites, as arranged by the regional offices. All people with developmental disabilities in Maine are eligible for services from the Dental Clinic. The Clinic does place a priority on serving people who require special expertise and/or anesthesiology services, and people who either do not have access to or do not have financial resources for community dental services.

In order to receive dental services through the Dental Clinic the person must:

1. Complete an application for dental services,
2. Have had a physical exam within the last year, and,
3. Make an appointment with the Clinic.

The role of the CM in arranging dental services at the Dental Clinic varies according to the consumer's individual circumstances. If the consumer has access to family members or service providers who can arrange for dental needs to be met at the Dental Clinic, the CM can simply describe the available services and monitor their delivery. In other instances, the CM will be the person actually responsible for setting up appointments at the Dental Clinic and for arranging transportation

For consumers who are 62 or over, Case Managers should investigate the "Senior Dent" program. Senior Dent is a program sponsored by the Maine Dental Association in cooperation with Area Agencies on Aging. It provides comprehensive dental care to low income elderly at reduced rates. Maine residents who are 62 or over, have not dental benefits under Medicaid or private insurance plan, and have an

income which qualifies them for the Low Cost Drug Program are eligible to enroll in Senior Dent. Eligible persons will receive a minimum 15 percent discount on all dental services from participating dentists.

Evaluations and Consultations

Any number of variables will enter into making a request for an evaluation or consultation, including sound judgment and common sense. Age, history, current programming and other evaluations should all be taken into consideration. The interdisciplinary team must be a part of the referral process so that team members can offer information and receive feedback from the evaluation. Such an approach strengthens the cooperative effort and helps the team to function with other consumers, as well as the person being referred.

Frequency of evaluations should be determined by the needs of the consumer and the evaluator. Evaluations for youngsters are frequently repeated every six months or yearly because of the child's rapid growth. Adults may need to be seen again every year or even every three years. The degree of intervention programmed by the specialist will also determine frequency of evaluation. Consultation should be done on an as needed basis with a note indicating the consultation has taken place. More frequent evaluations may be required for consumers in the waiver program and those subject to behavioral procedures.

The "why" of referral, evaluation and consultation seems obvious, but is often overlooked. The referring party should assist in not only gathering information for the specialist to use in the evaluation, but also to have in mind what is expected from the final report. A list of specific questions regarding the consumer would give the specialist or therapist a good starting point. The Case Manager might note that a certain problem showed up on a screening and ask why. Another problem might be evident, but strategy is the help being sought.

One important result of any evaluation is the final written report. This document should be received in a timely manner, and, if it isn't, then the referring person should work to expedite its release.

The four primary disciplines generally associated with services for the persons with mental retardation are occupational therapy, communication therapy, physical therapy and psychology. There is increasing recognition of recreation therapy as an integral part of programs for people with mental retardation. Newly recognized in Maine is art therapy, which is available on a very limited basis. For purposes of this section, the focus will be on the use of the four primary disciplines: These disciplines provide consumers with evaluations and therapy and deliver consultations, program design and a wide variety of general and specific in-service training to regional staff and providers. Other disciplines are briefly noted.

It is important for Case Managers to have a clear understanding of what types of intervention each discipline can provide. Understanding how each therapy can assist the person in his/her development will help the Case Manager make good judgments about when to refer and what questions to present to the therapist.

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Support services staff are a valuable resource to the Case Manager and they should be consulted whenever there is a question about a consumer's progress or development. For example, changes in a consumer's behavior may signal a need for a psychological evaluation or minor modifications in a person's person centered plan. Consultation with the psychologist can help determine the appropriate course of action. Also, the role of the occupational therapist with adult consumers can not be understated. Many adults with mental retardation have sensory problems that contribute to difficulty functioning in other areas. Consultation with the occupational therapist can help to identify and resolve these difficulties through appropriate person centered planning. Frequent consultation with support services staff will insure timely and appropriate intervention in a consumer's program.

Tips on Making Referrals

- Provide the therapist with relevant background information about the consumer, i.e., history, previous evaluations from within that discipline or from a related discipline.
- Ask specific referral questions, preferably in writing, when requesting the evaluation or consult.
- Assure that necessary release forms are signed.
- Make the referral one to three months prior to the date report is needed, and make sure evaluator is aware of relevant timelines, i.e., date of person centered plan.
- If the evaluator requests that referral form is completed, assure that this is done.
- Attempt to assure that a person who is knowledgeable about the consumer is available to the therapist or clinician at the time of the evaluation/consult.
- Request a qualified interpreter (if needed) immediately after the appointment is scheduled. Assist the therapist in locating interpreters who work well with the consumer.

Monitoring of Psychotropic Drugs

The caseworker's role with consumers who are taking psychotropic drugs is monitoring. It is the Case Manager's responsibility to check that psychotropic drugs are evaluated twice yearly, as ordered by the Consent Decree, with appropriate laboratory testing at a minimum of once a year and sometimes more often depending on the psychotropic medication. (i.e. Lithium monitoring occurs infrequently) The case manager should advocate for appropriate physical evaluation of the consumer before and during the psychotropic treatment. By periodically reviewing the medication records at a nursing home or ICF/MR, the caseworker will be able to follow the physician's review of a consumer's medication regime. For other consumer's, the caseworker should follow their medication reviews at local out patient clinics and/or contact the prescribing physician.

When a consumer is placed on a new drug, his/her reaction to the drug should be closely watched. Residential and day programming staff should observe the consumer for adverse physical and emotional reactions, as well as unintended behavioral changes. In some instances, the individual will have no reaction to the drug. In any of these cases, the caseworker should question the use of a particular drug they should discuss concerns with residential providers and the person's physician and discuss any concerns with the responsible physician.

If there is a sudden, unexplained change in a consumer's behavior, a medication evaluation should be considered. Also, it should be noted that an individual who has a long history with one drug should be evaluated for irreversible side effects and possible drug alternatives. In addition, medication side effects or concerns about polypharmacy should be brought to the attending Physician.

Occasionally, the prescribing physician will be unwilling to make changes in a person's drug schedule. If the consumer's behavioral or emotional problems persist, the caseworker should seek a second opinion to assure the most appropriate psychotropic medication is being utilized or bring their concerns to the attention of the DHHS Regional Medical Director.

Nutritionist

A nutritionist can assist in determining the nutritional status of an individual and any possible relationships to etiology or current problems, as well as to plan and implement a dietary change, if needed.

Indicators: metabolic disease, improper growth rate.

Obtaining a Second Opinion

Second opinions can be extremely useful in helping the consumer and/or family make informed decisions about medical and other types of treatment. There are two situations where second opinions should always be obtained.

These are:

1. When elective surgery is recommended for a consumer under public guardianship, and,
2. When a recommendation is made for "no code" or "no heroics" status for a consumer under

Public guardianship.

For consumers who have a private guardianship, the Case Manager should pursue a second opinion in both situations noted above.

There are a number of other kinds of situations where a caseworker should consider requesting another opinion. Some examples of instances where another opinion should be considered are:

- When radical surgery is recommended, i.e., removal of limb, organ, etc.
- when conflicting medical opinions are given regarding a course of treatment,
- when consumer's medical problem is not resolved, i.e., uncontrolled seizures,
- When consumer has received psychotropic medication over extended period of time, with no attempt at reduction/alterations in regime.

Non-Medical Second Opinion

There are also instances within other treatment modalities where second opinions can be useful. Some examples are:

- when there are conflicting opinions about whether a person should be considered to have mental retardation,
- Where there are conflicting recommendations from within a discipline or across disciplines, i.e., use of sign language vs. attempts at vocalization.

The standard that should be applied in deciding whether to seek a second opinion is the standard applied to the general population. The caseworker should ask, "If I were this consumer, would I want another opinion?" It is equally important to examine the purpose of obtaining another opinion. The primary purpose should be to clarify a course of treatment or to assist in making a decision affecting a consumer.

Second opinion should not be used to resolve unspecific concerns about physician or clinician competence.

Process for Obtaining a Second Opinion

In Most instances, the caseworker should approach the consumer's primary physician or clinician regarding the desire to pursue a second opinion about a particular issue. Getting agreement and cooperation will greatly enhance the chances of obtaining a meaningful and comprehensive second opinion. Extending the courtesy of discussing a possible second opinion and providing a clear rationale as to why it is desired will hopefully ensure needed cooperation. The person being asked to give the second opinion also needs to be informed about the rationale and about whether the primary physician concurred or not with the solicitation of a second opinion.

Once the second opinion has been obtained, the caseworker should assure that there is clear documentation in the consumer's record about the outcome and course of treatment. If for any reason the Case Manager is unable to obtain a second opinion, or continues to be dissatisfied with the consumer's progress; the Case Manager should bring it to the attention of the DHHS Regional Medical Director.

Occupational Therapy

Occupational therapy (OT) is concerned with stimulating independence and enhancing productive function. Occupational therapy concentrates on the areas of motor, perceptual motor, and personal/social skills. Indicators: Problems in reaching and grasping, poor self-help skills, difficulty in relating body to space.

An occupational therapist can useful in assessing and/or dealing with the following:

1. Balance problems not associated with skeletal or orthopedic problems.
2. Upper extremity problems including:
 - Strength, range of motion and/or deformities,
 - Fine motor coordination,
 - Asymmetry (not attributed to dominance).
3. Self-help skills.
4. Prevocational skills.
5. Sensory problems:
 - Eye movement,
 - Eye/hand/foot coordination,
 - Aversion to or lack of awareness of touch,
 - fear of movement/too much movement.
6. Tendency to not use either hands or arms for bimanual tasks.
7. Motor planning difficulty (problems learning new motor tasks).
8. Need for adaptive equipment or methods to decrease deformity or increase function for;
 - Vocational or prevocational tasks,
 - cooking,
 - Hygiene,
 - dressing

- Other daily living skills.

9. Visual/perceptual skills,

- Form and space perception,

- figure/ground perception, etc.

10. Social Skills

11. An occupational therapist can also help in determining learning style.

Physical Therapy

Physical therapy (PT) may be appropriate for persons who have problems with posture and locomotion.

Posture is the ability to assume and/or maintain the body, or segment of, in a specific position.

Locomotion is the ability to move from place to place. Indicators: poor postural reflexes, disorders of tone, movement, strength, balance, or coordination.

A physical therapist can be useful in assisting and dealing with the following:

1. Posture or general skeletal alignment involving spine and limbs.
2. Range of motion/joint flexibility/deformities such as severe flat feet, arm and leg joint tightness.
3. Gait (walking) or other means of mobility (creeping, wheelchair use).
4. Need for adaptive equipment to assist in safety, accessibility, positioning, or mobility.
5. Orthotic (braces) or prosthetic (artificial limbs) devices for back or legs.
6. Selection of proper shoes, shoe inserts and lifts.
7. Problems with balance equilibrium.
8. Coordination.
9. Pain related to movement.
10. Strength/endurance/
11. Muscle tone - too much (spasticity) or too little (hypo tonicity).
12. Gross motor skills.
13. Body mechanics for people or care givers.
14. Transfer techniques.

Referrals to Psychologist; Common Referral Questions/Reasons for Referral

Common Referral Questions/Reasons for Referral

1. Routine Psychological (Evaluation/Review)

(All referrals for therapeutic services must have a written physician's order to claim insurance)

Ask the psychologist to provide you with information relevant to areas which will be addressed in the Person Centered Plan or next case review. Specific areas in which one might request information are: consumer strengths, needs, long-term goals, priority short-term goals, types of placements which would meet needs, additional services may need, etc. Also, ask psychologist to address specific area you know will be discussed at the Person Centered Plan or case review (i.e., guardianship, behavior problems). If the psychologist has been seeing the consumer in therapy, but is unable to attend the Person Centered Plan, she/he may want to send information relevant to the Person Centered Plan.

2. Evaluation for Eligibility for Developmental Services

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Send psychologist a copy of Developmental Services eligibility guidelines so that she/he knows that both a low IQ (70) and problems in adaptive functioning are required for Developmental Services eligibility.

3. Guardianship

Ask the psychologist to assess the need for guardianship and/or conservatorship.

4. Psychological Evaluation to apply for and/or determine eligibility for another government agency (i.e., Vocational Rehabilitation, SSI).

Each agency has its own criteria, but it will help to get relevant information if you:

- a. tell the psychologist to which agencies the consumer is applying,
- b. ask psychologist to include a diagnosis in their report,
- c. ask psychologist questions relevant to the specific agency.

Vocational Rehabilitation requires the consumer to be handicapped, but to have vocational potential. Ask the psychologist to specify the person's handicapping conditions, including offering a diagnosis. Also, ask the psychologist to discuss the consumer's vocational potential and to make recommendations for how to develop this potential (i.e., recommended services).

5. Referral for evaluation of emotional/behavioral problems

There are a variety of reasons you might refer for evaluation in this area. Please specify your reason(s) for referral and the types of assistance you want/questions you want addressed. Examples of possible needs in this are as follows:

- a. Request for recommendations for behavior modification program. Be sure to specify types of consumer behaviors which are problematic and describe any interventions which have been tried so far.
- b. Evaluation for consumer suitability for psychotherapy. Tell psychologist if you want them to consider doing psychotherapy with this consumer themselves, or they may not realize this is a possibility. Also, ask for recommendations for how home and program can help with adjustment problems.

Section VI Financial/Regulatory

Case Management Billing

Case management billing is the mechanism by which the State's General Fund or the case management agency is reimbursed for the case management services provided. These services are documented as an Developmental Services General Note in the Enterprise Information System (EIS). There may be as many billable notes entered as there are billable contacts with or on behalf of the consumer.

For community case management billing processes set by the case management agency should be followed.

For state case management it is the CM's responsibility to document billing contact notes for all consumers on the CM's caseload by the 10th of the month following the end of the "contact month". The note must have the "Billable Note Box" checked "Yes" for the note(s) to be reported in the

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monthly billing statement. Also the "Contact Type" drop down box must have the correct or most correct type of contact selected. Multiple billable notes are acceptable and encouraged, however each note needs to meet the billable standard if check yes as only one note will be used for billing.

A contact is any exchange of information, in regard to a consumer. Contact may be anything from phone calls to/from providers to home or program visits. Representative payee responsibilities are not a billable service. Documentation of activity must be evident in the consumers' EIS records in order to be considered a contact. Also the Developmental Services General Note must meet the MaineCare quality standards for an acceptable note.

For State case management each consumer is assigned a billing number that is on file in EIS. Using this number and the dates of all "billable" notes, a case management billing report is prepared and sent to reimbursement by the 15th of the month. This billing report includes the following information from the EIS:

1. The CM's name,
2. The date of each billable contact for the month,
3. Each consumers billing number and name,
4. Each consumer's MaineCare Number,
5. People ID Number from the EIS, and
6. Housing Type

In the event, some notes have not been entered in the system prior to the submission of the billing statement, a manually prepared billing form must be completed and sent immediately to reimbursement. Back billing will not be possible in the EIS, thus manual billing is required for late documentation.

Service Agreement

The service agreement between the Department of Health and Human Services ("Department") and the named Service Provider/Agency ("Agency") is meant to serve both as the contractual prerequisite for securing funding from the Department and as a statement for the Agency's commitment to improving the quality of life for persons with mental retardation. Current copies of the Service Agreements can be found in the Additional Materials Section I of this document. Agreements can also be found in your regional office.

MEDICAID AGREEMENT FOR AGENCIES	THE MEDICAID SERVICE AGREEMENT FOR SMALLER HOMES
1. General Payment/Rate Agreement	1. Payment Agreement
2. Benefits and Deductions	2. Independent Capacity
3. Independent Capacity	3. Administrator
4. Administrator	4. Compliance With Applicable Law and Regulation
5. Equal Employment Opportunity	5. Records
6. State Employees Not To Benefit	6. Termination
7. Compliance With Applicable Law and Regulation	7. Service and Supports For The Consumer
8. Records	8. Client Outcome Indicator
9. Termination	9. Right of Entry
10. Medicaid Provider Agreement	10. Insurance
11. Services and Supports For The Consumer	11. Modification
12. Right of Entry	12. Entire Agreement

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13. Client Outcome Indicator	
14. Insurance	
15. Audit	
16. Assignment of transfer	
17. Background Checks	
18. Approval	
19. Modification	
20. Non-Appropriation	

Waiver

DEVELOPMENTAL SERVICES Class Requirements

WAIVER WAIVER - INITIAL	RECLASSIFICATION	ICF/MR GROUP OR NURSING CLASSIFICATION
<ol style="list-style-type: none"> 1.) All participants in this program must be determined to be financially eligible for MaineCare, Medicaid benefits. The Bureau of Family Independence (BFI) does this. 2.) There must be a current Individual Support Plan, less than one year old at time of classification, consumer or guardian if appropriate must sign plan. Plan must detail why there is a need for waiver services and that there is an apparent need for ICF-MR level of care and services. 3.) A signed Choice Letter dated after the date of the above plan, but before the first date of waiver services. 4.) A completed BMS-99 form signed by attending physician. Signature must be less than sixty day's old as of the date of received in the Central Office Waiver Services Division. 5.) A completed and signed waiver checklist that details the authorization of particular waiver services. 6.) If the consumer is found to be both financial and medically and there is an opening available for them they will be so notified by the Central Office staff. 	<ol style="list-style-type: none"> 1.) Participant must continue on-going Medicaid eligibility. 2.) Updated support plan less than one year old as of date for reclassification. There needs to be detail as to why this need is on going or remains in effect. 3.) An updated BMS -99 form that does not require a physician signature. 4.) A signed waiver checklist that details current authorizations. 5.) The above information is due in Central Office by the date of classification. 6.) Reclassification applications received after thirty working days of the review date shall be authorized for services as of the date the reclassification application is received. 7.) When the reclassification packet has not be received and processed after thirty-calendar days beyond the due date payment to the provider will stop, until such time that the classification is completed. 	<ol style="list-style-type: none"> 1.) Participant must be determined financially eligible for MaineCare benefits for this level of care. 2.) A recent plan of care less than six months old needs to recommend such placement. This most commonly is the pre-placement meeting that takes place less than 30 day's prior to placement. 3.) A psychological evaluation that is less than three months old. This should document that the individual is likely to benefit from the placement into such a facility. 4.) A completed BMS-85 form and physical signed by a physician that is completed no sooner than seven day's prior to admission and no later than forty-eight hours following admission. 5.) It is the responsibility of the receiving facility to make sure that number four above is completed, however case-management staff will often assist with this responsibility.

Developmental Services Cannot Classify an Individual Going into a State Facility.

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That is done by:

**BMS Classification Review
State House Station #11
Augusta, Maine 04333
Telephone # 287-3931**

Payment will not be made until individuals are classified