

**DIVISION CIRCULAR #22  
(N/A)**

**DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES**

**EFFECTIVE DATE: JUNE 21, 2004**

**DATE ISSUED: June 11, 2004**

(Rescinds Division Circular #22, "Referrals for Placement from Developmental Centers to Community Based Alternate Living Arrangements," issued April 27, 1998.)

- I. **TITLE:** Referrals for Placement from Developmental Centers and Transfers to Community Living Arrangements.
- II. **PURPOSE:** To establish policies and procedures for the appropriate placement of individuals from developmental centers into community living arrangements.
- III. **SCOPE:** This circular applies to all components of the Division as well as providers under contract with or regulated by the Division.
- IV. **POLICIES:**
  - Planning for the transfer of an individual to a less restrictive living arrangement evolves through the Individual Habilitation Plan (IHP).
  - An individual receiving services shall be placed in the least restrictive environment available which specifically meets his or her needs.
  - The decision to transfer from the developmental center is effected in concert with the individual and/or parent or legal guardian, the Interdisciplinary Team (IDT) and the availability of resources. Disagreements with the decision to transfer may be appealed in accordance with Division Circular #37.
- V. **GENERAL STANDARDS:**
  - A. **Definitions** - For the purpose of this circular, the following meanings shall be applied to the terms used:

“Case Manager” means the Division employee who is responsible for the linking and coordination of services across family, agency and professional lines to develop and attain goals and objectives embodied in the Individual Habilitation Plan. The role of the case manager involves monitoring and advocating for the individual’s needs with the individual and/or the parent or legal guardian and family’s participation.

“Community living arrangement” means residences for individuals with developmental disabilities that include but are not limited to group homes, supervised apartments, community care residences, supportive living programs as well as community Intermediate Care Facilities for the Mentally Retarded (ICF/MR). This may also include community living arrangements as well as nursing and boarding homes not licensed by the Department of Human Services.

“DC Social Worker” means the developmental center employee who is responsible for ensuring communication between the individual, parent and/or legal guardian, family members and facility staff on the individual’s needs and rights, as well as providing counseling needs and referrals for transfer.

“Director of Social Services (DSS)” means the developmental center employee who is responsible for the supervision of the DC social workers and the implementation of facility initiatives.

“Habilitation Plan Coordinator (HPC)” means the developmental center employee who serves as the team leader for development of the Individual Habilitation Plan and other service plans. The HPC serves as the chair of plan meetings and ensures that the plans are implemented.

“Incapacitated” means the individual is determined by the court to be unable to make decisions and manage his or her affairs to the extent that he or she requires a legal guardian to make some or all decisions on his or her behalf.

“Individual” means a person who is receiving services from DDD.

“Individual Habilitation Plan” (IHP) - Refer to Division Circular #35.

“Interdisciplinary Team” (IDT) - Refer to Division Circular #35.

“Legal Guardian” means the parent of a minor or the person or agency appointed by a court of competent jurisdiction, or otherwise legally authorized, and responsible to act on behalf of an incapacitated adult to assure provision for the health, safety, and welfare of the individual and to protect his or her rights.

“Parent” means the natural or adoptive parent of an individual, or person who has legal custody of an individual under age 18.

“Placement” means any action taken by the Division that provides for an individual’s need for residential services or day program.

"Pre-placement IHP" means a written plan of services that is developed by the Interdisciplinary Team and is used to effectuate the transfer of an individual from the developmental center to a community living arrangement.

“Provider Agency” means a public or private agency under contract with the Division to provide services to Division individuals who have developmental disabilities.

"Transitional Case Manager (TCM)" means a Community Services placement worker who serves as the link between the developmental center and a regional office for the identification and subsequent transfer of individuals from the developmental center to community services.

“Transfer” means moving an individual from a developmental center to a community living arrangement.

- B. Pre-placement plans targeted towards placing an individual in a community living arrangement are developed through the combined efforts of the developmental center and community services staff together with the service provider, individual, parent and/or legal guardian.
- C. The assigned TCM shall inform staff of each developmental center regarding the availability of community vacancies and specific provider criteria for admission.
- D. Division staff shall be aware of the rights of the individual and/or his or her parent or legal guardian to accept transfer. If the individual is incapacitated, but can express a clear preference for where he or she wishes to live, the wishes of the individual shall be weighed into the decision. If the individual is incapacitated, his or her parent or legal guardian shall be the decision-maker.

## **VI. PROCEDURES:**

### **A. Identification of Individuals for Community Living Arrangement**

1. When the IDT identifies an individual as appropriate for a community living arrangement, the IDT shall identify the supports needed for a community living arrangement. If an individual's preferences about living arrangements are not already part of the individual’s IHP, the IDT should incorporate them into the IHP through an IHP modification. The DSS or designee shall keep a list of individuals identified as appropriate for

community living arrangement. The TCM shall contact the DSS or designee when a potential vacancy is identified.

- a. Staff of the developmental center shall inform, in writing, the individual and/or parent or legal guardian of the referral to the TCM.
  - b. The referral to the TCM shall include a summary of the individual's support needs and background information.
  - c. The TCM may request additional information as necessary.
2. For those individuals identified for a community living arrangement, the TCM shall complete the Community Services Adaptive Behavior Summary (ABS) with input from the staff of the developmental center.
  3. The preferences of the individual shall be utilized by regional staff to identify potential providers and programs.
  4. After reviewing the individual's information, the TCM shall notify the developmental center, in writing, within 90 calendar days if appropriate community resources are available.
  5. If a community living arrangement is available, staff of the developmental center shall compile and forward a referral package to the TCM. The referral package shall include the following, as applicable:
    - a. Admission data (developmental center);
    - b. Adaptive Behavior Summary;
    - c. Behavior information, including current behavior plan and history of previous attempts to modify the behavior;
    - d. Social Data and/or Social history;
    - e. The DDD Medical Form for Adults/Children within the last 12 months, and medical documentation in accordance with Division Circular #10, including Mantoux testing with documented results, Hepatitis B status;
    - f. Medical history including medication and immunization;
    - g. Documentation of known allergies;
    - h. Seizure records and/or neurological examination;
    - i. Dental Information;
    - j. The most recent psychological and psychiatric evaluations;
    - k. Current audiological evaluation;
    - l. History of hospitalization;
    - m. Vision testing;
    - n. Current IHP;
    - o. Guardianship status; and
    - p. Summary of incidents for the last year.

6. The TCM shall provide the referral package as described in subsection A.5. to the potential provider(s).

## **B. Pre-placement Planning Procedure**

1. When an individual is being considered by a provider agency for admission, the provider agency, through the TCM, shall:
  - a. Have access to the individual's entire client record, with supervision;
  - b. Have the opportunity to meet with the individual, privately (if the individual agrees);
  - c. Have the opportunity to interview developmental center direct care and program staff concerning the individual's needs and abilities;
  - d. Have the opportunity to meet or speak with the individual's family or legal guardian, if the family or legal guardian agrees;
  - e. Offer a day and/or overnight stay at the living arrangement for the individual;
  - f. Offer the parent or legal guardian and/or family an opportunity to visit the living arrangement; and
  - g. Offer the individual, parent or legal guardian and/or family the opportunity to visit the proposed day program, if a day program is available.
2. If a pre-placement visit is scheduled, the DC social worker shall provide a copy of the written consent for emergency treatment to be signed by the individual, parent or legal guardian. A copy of the release for medical treatment form located in the client record may be utilized in the absence of a written consent for emergency treatment signed by the individual, parent or legal guardian;
3. The TCM and the DC social worker shall review available placements options with the individual and/or his or her parent or legal guardian and/or family. The options shall be confirmed in writing by the TCM.
4. The TCM completes a Day Program/Employment referral package and sends it to the Community Services (CS) Day Program Coordinator. The CS Day Program Coordinator will process the referrals for a Day Program/Employment placement and will advise the TCM of day program/employment provider information once determined.

5. Staff of the selected day program/employment program shall receive the same referral package information as the staff of the residential program. This information shall be provided by the CS Day Program Coordinator.
6. The provider agency will advise the TCM if the individual has been accepted or declined by the agency.
7. The TCM will advise the individual, parent or legal guardian, in writing, if proposed community living arrangement is accepted or declined.
8. The individual and his or her parent or legal guardian and/or family shall make a selection or decline all offers of placement within the time period specified by the Division, but no more than 30 days.
9. If all parties have agreed to placement selection, transfer planning will commence.

### **C. Transfer Plan**

Upon selection of the provider agency, the following actions will be taken by DDD and the Provider Agency, prior to the day of transfer:

1. DDD Responsibilities:
  - a. A Pre-placement IHP shall be developed at least 30 days prior to a move.
    - i. The TCM and DC HPC shall be responsible to develop the Pre-placement IHP. The TCM authors the Pre-placement IHP.
    - ii. Attendance at the Pre-placement IHP meeting is required for the following individuals:
      - Community Services' case manager or case management supervisor;
      - Provider agency representative;
      - TCM;
      - DC Social Worker; and
      - DC HPC.
    - iii. The following individuals shall be invited to attend the Pre-placement IHP meeting:
      - The individual who has been referred for placement;
      - Parent or legal guardian and family; and
      - Individuals who would represent the services supporting the individual in the community.
    - iv. The Pre-placement IHP shall address all supports required for successful transition. The plan shall specifically address:

- (a) The goals that must be met for transfer to be successful;
  - (b) The services, supervision and living arrangements that are needed; and
  - (c) A transition calendar, that states how often the individual being referred will visit the proposed new residence, to include: length of stay, if staying overnight; transportation, etc.
- v. The TCM shall obtain the signature of the competent individual, parent of a minor or legal guardian of the incapacitated individual, on the "Freedom of Choice" Form selecting Community as the option for service delivery.

- b. A transfer date shall be established by the IDT at the Pre-placement meeting. Within five working days, the TCM will provide written confirmation of the transfer date to the individual, parent or legal guardian, provider agency(s), CS Area Supervisor for Case Management and the developmental center.
- c. Between two weeks and 30 days prior to discharge, the DC/Supervisor of Patients Accounts prepares the application (SS-11-BK Social Security Administration Form) for Social Security Income (SSI) and/or SSA benefits on behalf of the consumer and forwards the completed, unsigned copy to the CCW Regional Fiscal Coordinator. On the actual date of the move, the Fiscal Coordinator will sign the completed application on behalf of the Division, initial the application, and forward to the Social Security District Office (SSDO).
- d. DC staff will complete a clothing inventory and will purchase additional clothing two weeks prior to day of transfer, if needed.

## 2. Provider Agency Responsibilities

- a. The agency begins transition activities as soon as the final decision has been made for the individual to move to the community residence. Agency staff will maintain regular contact with the individual up to the time of the actual move to the residence.
- b. Agency staff will participate in pre-placement meetings and will begin planning for the transfer of the individual. The agency's responsibilities during the meeting are as follows:
  - i. To ensure consistency of care for those individuals receiving ongoing medical treatment, including medication, the agency will identify medical personnel who will be involved with the individual in the community, and schedule appointments at least 30 days prior to day of transfer;
  - ii. If the need for a Behavior Support Plan (BSP) has been identified, an agency representative will participate in meetings

- to develop an appropriate BSP for the community living arrangement prior to transfer;
- iii. The Agency will provide transportation for the individual and his or her clothing and possessions to the community living arrangement on the day of transfer;
- iv. The Agency staff will discuss with the individual his or her recreational interests and available activities; and
- v. The Agency staff will have the individual, parent or legal guardian sign all applicable agency consents, and policy and procedure forms.

**D. DDD and Provider Responsibilities for Day of Transfer and Within 30 days of Transfer**

1. On the day of transfer, the following shall be provided by the developmental center to the TCM. The TCM will ensure that the required documents and information will be provided to the provider agency and Community Services Regional Office:
  - a. The entire client record;
  - b. Original or raised seal copy of Birth Certificate;
  - c. Social Security Card;
  - d. The individual's financial information sheet, and a copy of the application for SSI/SSA benefits that was forwarded to the Fiscal Coordinator;
  - e. A written medical certification that the individual is contagion free completed within 72 hours prior to the transfer;
  - f. A medical summary in accordance with Division Circular #10;
  - g. The individual's clothing and other personal belongings, along with an inventory. The individual, agency representative, TCM and developmental center staff are to check the individual's bedroom to ensure that all items, including seasonal clothing, have been packed. The agency representative will sign a receipt for the items;
  - h. Personal funds, as determined at the Pre-placement IHP meeting, shall be provided and a receipt for the funds signed by the agency staff;
  - i. A 30-day supply of medication, in appropriately labeled container(s), for the community living arrangement and day program, if applicable, will be provided to the Agency representative;
  - j. One original prescription, and two legible photocopies of each prescription stamped "duplicate", shall be provided. One duplicate copy is for the residential program; the other copy is for the day program/employment program. The original prescription is for the pharmacy;
  - k. Current Medicaid/Medicare verification, if applicable;
  - l. The names and telephone numbers of developmental center staff who can serve as a resource to the individual and the provider

- agency during the transition and the names, addresses, and phone numbers of the individual's family, friends and advocates;
- m. The signed "Freedom of Choice" form; and
  - n. Completes appropriate forms, as required.
2. On the day of transfer, the TCM will ensure that all appropriate parties have been notified of the transfer.
  3. The provider agency shall be informed of the assigned Community Services case manager no later than the date of transfer. The Community Services Case Manager is the DDD contact effective the day of transfer.
  4. The Agency will obtain photo identification for individual within seven days following the day of transfer.
  5. The Agency will open bank account in individual's name within seven days following the day of transfer, provided sufficient funds are available to do so.
  6. The provider agency staff will remain in ongoing communication with developmental center social worker during the first 30 days of transfer.

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James W. Smith, Jr.  
Director

**DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)**

**SUBJECT: Transfer of Individuals from Developmental Centers to Long Term Skilled Nursing Facility Placements**

**EFFECTIVE: February 8, 2005 (Revised)**

**POLICY:** DDD staff will adhere to the applicable procedures as described in Division Circular #22 and this appendix when transferring an individual to a skilled nursing facility from a developmental center for long term placement.

**STANDARDS:**

- 1) Definitions – for purposes of this policy, the following term(s) shall have the meaning defined herein:

“PASRR” means the Pre Admission Screening and Resident Review. PASRR process is a federally mandated program for screening applicants and residents of Medicaid-certified Nursing Facilities for mental illness, mental retardation and/or related conditions.

- 2) The developmental center medical staff, and outside medical personnel as necessary, shall determine an individual’s need for skilled nursing facility placement.
- 3) The PASRR form is completed by assigned developmental center component.
- 4) Once the individual has been accepted for placement into a skilled nursing facility, the developmental center staff will notify the appropriate Community Services Regional Office, in writing or via electronic mail (email), no less than seven (7) days prior to the placement, where possible. The Regional Fiscal Coordinator is to be copied on the notification to initiate the process for the transfer of client funds.
  - a) The notification shall include the following information:
    - i) Individual’s name;
    - ii) Date of birth;
    - iii) Guardianship status;
    - iv) Address of skilled nursing facility;
    - v) Name and phone number of contact person at skilled nursing facility;
    - vi) Anticipated transfer date; and
    - vii) Name and phone number of contact person at the developmental center.
- 5) The developmental center staff will notify the individual, parent and/or legal guardian, and involved family members of the skilled nursing facility

- placement, including the date of the placement, the location of the skilled nursing facility and name and phone number of contact person at the skilled nursing facility, prior to the placement. The developmental center staff will follow-up, in writing, to the family.
- 6) The developmental center staff will provide all required documentation to the skilled nursing facility.
  - 7) The developmental center staff will transfer the client record to the Region within 30 days of the individual's transfer to the skilled nursing facility.
  - 8) The developmental center staff will provide a receipt with the client record. The Region will sign the receipt and return the completed receipt to the developmental center.
  - 9) The developmental center will remain the responsible Division component following the transfer of the individual to the skilled nursing facility. Thirty (30) days after receipt of the client record, the Region will assume responsibility for the individual.
  - 10) The developmental center staff will remain available to the skilled nursing facility and Region for inquiries relating to the individual.
  - 11) The developmental center will provide the necessary clothing and personal possessions to the individual at the time of placement in the skilled nursing facility.
  - 12) The developmental center, in coordination with the individual and his or her private guardian and/or family, will be responsible for the disposition of other personal possessions.
  - 13) The developmental center and Regional staff will develop a Plan of Care in accordance with Division Circular #35.
  - 14) Each developmental center will determine the appropriate staff responsible for the functions as described above.