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NORTH Dakota Be Legendary.

Health & Human Services

# COMMUNITY TRANSITION SERVICES

This chart provides an overview of ND Medicaid funded Community Transition Service (CTS) options in North Dakota. CTS should be accessed through the MFP grant whenever possible. After ruling out MFP as an option, then another of the four options should be utilized.

| MFP Grant | ADRL Transition Services | Community Transition Services- HCBS Waiver | Community Transition Services- DD Wavier | Community Transition Service 1915(i) HCBS Behavioral Health |
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| **Overview**<br>The purpose of the MFP Grant Program is to assist Medicaid eligible individuals with transitioning from an institutional setting back to a qualified community home | **Overview**<br>Program assists individuals with a disability of any age to transition from a provider operated residential situation back to a community residence. ADRL Transition can be utilized for individuals who do not otherwise qualify for the MFP Grant or Community Transition Wavier services. The residential situations can include nursing facilities, basic care facilities, assisted living facilities, homeless shelters, or other COVID-19 related group living environments. | **Overview**<br>The purpose of CTS is to assist eligible individuals transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the individuals directly responsible for his/her own living expenses and needs non-recurring set-up expenses. | **Overview**<br>Community Transition Services is a one-time cost for non-recurring set-up expenses for participants who are transitioning from an institution to a home and community-based setting where the participant wishes to reside. | **Overview**<br>CTS is one-time funding for non-recurring set-up expenses for individuals who are transitioning from a qualified institution to a qualified private residence, and are reasonably expected to enroll in the 1915(i) within 90 days of the approval of the community transition service<br><br>See the 1915(i) policy for full details:<br>Community Transition.pdf (nd.gov) |

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| **Program Highlights**<br>• MFP can assist individuals who may not meet Nursing Facility (NF) Level of Care (LOC) screening requirements at discharge.<br>• Assists with transitions only for those individuals with a 60-day or longer institutional admission.<br>• Provides the same level of transition service prior to discharge as HCBS CTS.<br>• Can pay for 1st month's rent as part of a rental deposit.<br>• Individual has access to the MFP Grant Rental Assistance Program<br>• Able to pay for food assistance.<br>• Provides up to 365 days of transition coordination support after discharge.<br>• Provides additional support services not available in the waiver to assist with adjustment to community living | **Program Highlights**<br>• No income limitations<br>• Assist with any group living environments.<br>• Helps individuals with a disability to return to community living.<br>• Provide up to $1,500 in moving cost assistance.<br>• Can provide temporary assistance with rent. | **Program Highlights**<br>• Must be reasonably expected to meet NF LOC screening requirements at the time of discharge.<br>• No waiting period: Can make referral for CTS at the time of admission to an institution or another provider-operated living arrangement.<br>• Provides the same level of transition service prior to discharge as MFP.<br>• Provides one-time moving costs up to $3000 per recipient.<br>• Provides up to 90 days of transition coordination support after discharge.<br>• Involves the HCBS Case Manager from the beginning of the process | **Program Highlights**<br>• Funding for non-recurring set-up expenses for those transitioning from an institution to a home and community-based setting where the participant is directly responsible for their living expenses | **Program Highlights**<br>• 1915(i) CTS consists of funding only.<br>• CTS case management is not included in 1915(i), thus case management activities occurring prior to 1915(i) enrollment, which occurs following the individual's discharge, are not reimbursable through 1915(i).<br>• CTS funding may be authorized up to 90 consecutive days prior to the individual being determined eligible for the 1915(i) and may continue for 90 consecutive days from the date the individual became eligible for the 1915(i) for a total of 180 consecutive days. |
| **Qualified Individual**<br>• Has been in a qualified institution at least 60 consecutive days<br>• Has been in multiple qualified institutions during the 60 days provided the days were consecutive | **Qualified Individual**<br>• Individuals with a disability of any age living in a provider operated residential situation who are transitioning back to community residence who do not otherwise qualify for the MFP Grant or Community | **Qualified Individual**<br>• Must be on Medicaid.<br>• Must be eligible for the Medicaid Waiver for HCBS<br>• Must be at least age 18.<br>• The care needs of the individual must fall within the scope of CTS. | **Qualified Individual**<br>• Must be on Medicaid<br>• Must be reasonably expected to be eligible for and enroll in the waiver<br>• Must be receiving DD Program Management | **Qualified Individual**<br>• Individual has resided in the qualified institution for a minimum of 30 consecutive days, has an anticipated discharge date, and will be discharged to a qualified residence. |

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| • Is on Medicaid at least the last day prior to transition | Transition Wavier services. (This program has no income requirements). | • Prior approval from an HCBS Program Administrator is required before this service may be authorized. | • Must have started discharge planning with an anticipated admissions date<br>• Resided in a ND Medicaid Institution for minimum of 60 consecutive days. | • Individual is reasonably expected to be eligible for the 1915(i). 1915(i) eligibility includes Medicaid enrollment, income - 150% of the Federal Poverty Level, qualifying 1915(i) Diagnosis, and minimum WHODAS complex score of 25. |
| **Qualified Institutional Setting**<br>Hospitals, Nursing Facilities, Swing Bed, Intermediate Care Facilities/IDD | **Qualified Institutional Setting**<br>The residential situations can include nursing facilities, basic care facilities, assisted living facilities, homeless shelters, or other COVID-19 related group living environments. | **Qualified Institutional Setting**<br>Institutions or other provider-operated living arrangements to include a skilled nursing facility, adult residential, adult foster care, basic care, and assisted living. | **Qualified Institutional Setting**<br>ND Medicaid Institution (hospital, nursing facilities, ICF/IDD) | **Qualified Institutional Setting**<br>Nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities, Qualified Residential Treatment Program, Psychiatric Residential Treatment Facility, hospitals (excluding the State Hospital and other hospitals which are IMDs) |
| **Qualified Residence**<br>• A home owned or leased by the individual or the individual's family member.<br>• An apartment with an individual lease; and lockable access; and egress windows; and living, sleeping, cooking, and bathing areas over which the individual or their family member has control<br>• "Apartment Style" Assisted Living settings can sometimes meet the requirements of an apartment | **Qualified Residence**<br>• Community residence such as an apartment or own home. | **Qualified Residence**<br>• A living arrangement in a private residence where the individual is directly responsible for his/her own living expenses and needs non-recurring set-up expenses | **Qualified Residence**<br>• Individual must be directly responsible for his/her own living expenses.<br>• Setting is with 6 or fewer people. | **Qualified Residence**<br>• A living arrangement in a home and community-based private residential setting where the individual is directly responsible for his/her own living expenses. |

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| • A community-based residence where no more than four unrelated individuals reside. | | | | |
| **Services** (Provided by CILS)<br>• Transition Coordination 180 days or more prior to discharge and 365 days after discharge<br>• $3,000 or more in one-time moving costs<br>• 24-hour backup nursing call service<br>• Adjustment Support services from a Qualified Service Provider<br>• Access to MFP Rental Assistance and payment of first month's rent as part of a rental deposit<br>• One-year follow-up services to Transition Coordination | **Services** (Provided by CILs)<br>• **Transition Coordination Services**: Helps with planning and coordination of services for a successful transition to community living.<br>• **Moving Costs**: Onetime payment up to $1,500 for return to community costs to enable successful transition to community living.<br>• **Rent Assistance**: Payment of monthly rent costs for individuals returning to the community. The length of time to cover rent costs will be approved on a case by case and based on the amount of funding available. | **Services** (Provided by an approved QSP Agency)<br>• CTS may be authorized up to 180 consecutive days prior to admission to the waiver of an institutionalized person and 90 days from the date the individual became eligible for the waiver.<br>• **Transition coordination** (TC) is limited to 300 hours or 1200 units per recipient.<br>• **One-time set-up expenses** are limited to $3000 per recipient.<br>• TC: Assisting with finding housing to include searching, coordinating deposits, and/or utility set-up; helping participants set up their households by identifying needs, help with shopping, and/or selection of household goods; arranging the actual move by getting things out of storage, and/or finding movers; identifying the community in which the participant wants to live; identifying and coordinating transportation options for the move; and assisting with | **Services** (Provided by DD provider agency)<br>One-time transition cost limited to up to $3000 per eligible individual per waiver period.<br>• Funding for the purchase of essential household furnishings for use within the home including furniture, window coverings, food preparation items and bed/bath linens<br>• Moving expenses<br>• Set-up fees or deposits for utility or service access including telephone, electricity, heating, water | **Services** (Provided by the entity requesting the CTS funding)<br>• The entity who originates the CTS funding request assumes the role of the CTS Case Manager. This will typically be a case manager from the institution the individual is being discharged from; or the individual's DD, SMI, Aging, Foster Care, DJS, etc., case manager.<br>• The CTS Case Manager must continue to provide oversight of the CTS funding for an additional 90 consecutive days past the date of 1915(i) eligibility or until the duration of the CTS request has expired.<br>• Maximum funding up to $3,060 per lifetime.<br>• Allowable expenses include security deposits, essential household furnishings, moving expenses, set-up fees or deposits for utility or service access, services necessary for the health and safety of the individual, i.e., pest eradication and one-time cleaning prior to occupancy, |

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| | | community orientation to locate and learn how to access community resources. | | and home accessibility adaptations |
| **Referrals**<br>Referrals can be made to the local Center for Independent Living Center, through the Aging and Disabilities Resource Link at CareChoice@ND.gov or by calling 1-855-462-5465. The MFP Grant Administrator can also be contacted for any referral. | **Referrals**<br>• Referrals can be made directed to the Aging and Disabilities Resource Link<br>• ADRL staff will make referrals to the MFP Grant Program Administer or the CIL serving the location.<br>• Center for Independent Living can accept referrals directly with notification to be provided to the MFP Grant Program | **Referrals**<br>Referrals are to be made through the Aging and Disabilities Resource Link at CareChoice@ND.gov or by calling 1-855-462-5465. | **Referrals**<br>During the service plan/discharge development process, the team will identify the anticipated items and cost that will be necessary for a successful transition. Individual, Legal Decision Maker, Provider, and DDPM, need to be part of the transitional meeting before the individual moves. The team will complete the Transitional Budget Form – SFN 1862 with necessary signatures. The Regional Staff will submit the form to the DD State Office for prior approval. | **Referrals**<br>During the discharge planning process, the team will identify the anticipated items and costs that will be necessary for a successful transition. The entity requesting the CTS funding assumes the role of the CTS Case Manager and completes the *1915(i) CTS Plan of Care and Request for Funds* form Plan of Care - CTS.pdf (nd.gov), and submits to the 1915(i) Medicaid Administrator for review and approval.<br><br>Following approval, the CTS Case Manager, in collaboration with the individual, works directly with Veridian Fiscal Solutions to purchase items. For process details see: Community Transition Service Process Flow.pdf (nd.gov) |
| **Contact Information**<br>Jake Reuter, MFP Grant Program Administrator<br>Aging Servicers: Phone- 701-239-7133<br>Cell: 701-680-9638<br>jwreuter@nd.gov | **Contact Information**<br>Jake Reuter, MFP Grant Program Administrator<br>Aging Servicers: 701-239-7133<br>Cell: 701-680-9638<br>jwreuter@nd.gov | **Contact Information**<br>Kristi Clark, Aging Service Program Administrator<br>701 328-8970<br>kriclark@nd.gov | **Contact Information**<br>Kayla Fender, Services Administrator; DD Division<br>701-328-8941<br>kefender@nd.gov | **Contact Information**<br>Dawn Pearson<br>Medical Services 1915(i) Administrator<br>701-328-2330<br>drpearson@nd.gov |