CTLP Transition Coordination with State Agency Programs

Revision History

Date	Version	Description	Author
December 4, 2023	1.0	Initial Publication	EOEA Home Care Team

This document describes how CTLP will collaborate with other state agency programs for transition coordination.

Click on the agency names below to navigate to the specific agency's programs.

DDS Programs

- Acquired Brain Injury Residential Habilitation (ABI-RH) and Moving Forward Plan Residential Supports (MFP-RS) Waivers
- Adult ID Waivers

DMH Programs

- Recovery Learning Community (RLC)
- Clubhouse

EOEA Programs

- Frail Elder Waiver (FEW)
- Home Care Services

MFP Demonstration

MRC Programs

- Acquired Brain Injury Non-Residential (ABI-N) and Moving Forward Plan Community Living (MFP-CL) Waivers
- Supported Living (SL) Program and Supported Living Expansion Program
- Statewide Head Injury Program (SHIP) and Traumatic Brain Injury (TBI) Waiver

Program Services Table

DDS/CTLP Transition Coordination

Acquired Brain Injury Residential Habilitation (ABI-RH) and Moving Forward Plan Residential Supports (MFP-RS) Waivers

What are the ABI-RH and MFP-RS Waivers?

- These **home and community-based service (HCBS)** programs are designed to transition eligible adults from nursing facilities, chronic or rehabilitation hospitals and psychiatric hospitals to qualified community settings and to furnish home or community-based services to the waiver participants following their transition from the medical facility setting.
- These waivers are for **adults who need 24-hour supervision and staffing in a provider operated residence including group homes, assisted living apartments, or shared living arrangements**.

Who is eligible to participate in these programs?

- **The ABI-RH Waiver** is available to individuals who have been living in a nursing facility, or a chronic disease, rehabilitation, or psychiatric hospital for **at least 90 days and have an Acute Brain Injury (ABI)**. Specifically, an individual must:
    - **Have experienced an ABI at age 22** or older. An ABI can result from a stroke, brain trauma, infection of the brain (such as encephalitis), brain tumor, or anoxia (lack of oxygen)
    - Meet financial eligibility requirements
    - Require a facility level of care (LOC)
    - Have an ongoing need for, and receive waiver services at least once a month
    - Be able to be safely served in the community with available waiver and MassHealth State Plan services
- **MFP-RS Waiver** is available to individuals who have been living in a nursing facility, or a chronic disease, rehabilitation, or psychiatric hospital for **at least 90 days**. Specifically, an individual must:
    - **Either be 18 years of age or older and have a disability, or be 65 years of age or older**
    - Meet financial eligibility requirements
    - Require a facility level of care (LOC)
    - Have an ongoing need for, and receive waiver services at least once a month
    - Be able to be safely served in the community with available waiver and MassHealth State Plan services

For ASAP Utilization. Do not Distribute

DDS/CTLP Transition Coordination

Acquired Brain Injury Residential Habilitation (ABI-RH) and Moving Forward Plan Residential Supports (MFP-RS) Waivers

What additional information about the program is available?

- ABI-MFP Participant Handbook
- Brochures are available in English, Spanish, Chinese, Haitian-Creole, Portuguese and Vietnamese

How do I make a referral or submit an application?

- Applications are available in English and Spanish online: ABI: https://www.mass.gov/info-details/acquired-brain-injury-abi-waivers#about-the-program-;
- MFP: https://www.mass.gov/info-details/moving-forward-plan-mfp-waivers#mfp-waiver-application-process-and-applications-
- **CRITICAL STEP**: Complete the section of the application that asks for the name and contact information of the CTL working with the consumer to allow communication with CTLP by UMASS and program case managers (once the consumer is eligible)

Are there any timing considerations for when to submit an application?

- No. Applications to participate in the program may be submitted **at any time during a facility stay.** However, consumers will not be eligible to receive waiver services if they are discharged prior to being in the facility for 90 days.

What is the process after an application is submitted?

- ABI or MFP Waiver Unit reviews and follows up on applications to determine clinical eligibility

If I have questions about my consumer's application, who do I contact?

- UMASS ABI Waiver Unit (ABIinfo@umassmed.edu); or 1-866-281-5602 (TTY: 1-800-596-1746)
- UMASS MFP Waiver Unit (MFPinfo@umassmed.edu); or call 1-855-499-5109 (TTY: 1-800-596-1746)
- If consumer has applied for both programs, you may contact either of the waiver units.

Will I be updated on the status of the application?

- If you are listed on the waiver application as an authorized representative
- Your consumer may choose you to be an authorized representative to help them with their application. They can do this by completing a MassHealth Authorized Representative Designation Form which they can get online or from the ABI Waiver Unit.
- The CTL will be notified when the consumer is in the community if you provided your contact information on the application.

For ASAP Utilization. Do not Distribute

DDS/CTLP Transition Coordination

Acquired Brain Injury Residential Habilitation (ABI-RH) and Moving Forward Plan Residential Supports (MFP-RS) Waivers

What types of support might I be asked to provide during the application process?

- Some consumers may not yet have completed a MassHealth application (called the Application for Health Coverage for Seniors and People Needing Long-Term-Care Services or SACA). You may be asked to help track down the information needed to complete the application.
- Other information that you may be asked to help track down may include signatures to approve release of medical records.

What is the process once a CTL consumer is determined eligible for the program?

- The information is sent to a DDS unit that specializes in ABI/MFP in the regional office.
- A service coordinator will be assigned, and they will begin transition planning.
  - They will determine the best living situation whether it be a group home or shared living.
- Once the service coordinator begins, CTLs will close the consumer's enrollment record in A&D and indicate that they were discharged to the waiver program.
- You may continue to support the consumer if the service coordinator requests assistance.
- It can take as short as two months or as long as 12-18 months to find a placement for the individual.

Will I be leading the transition to the community, or will another agency be doing this?

- No. A service coordinator from DDS will be assigned to help the person transition to the community. They may seek out your assistance if they need support with paperwork and referral processes, however they will lead the plan for the transition.

How might I be helpful to the consumer once they are determined eligible if I am not the lead on the transition? (on demand discharge support)

- The service coordinator may seek out your assistance if they need support with paperwork and referral processes. They may seek support if there is a MassHealth eligibility issue that arises during the time they are awaiting placement (e.g., eligibility redetermination paperwork), help coordinate with the Nursing Facility social worker with advocacy for readiness or to submit a timely SC-1 form at discharge or may be asked to help find the consumer a primary care provider in the community.

If I am leading the transition to the community, what are some of the activities I will be doing?

- N/A

For ASAP Utilization. Do not Distribute

DDS/CTLP Transition Coordination

Note: CTLP staff will not refer for these waivers. For individuals with confirmed Intellectual Disabilities through PASRR by DDS, DDS will support the application process and if determined eligible, may seek CTLP team support for complex discharges.

DDS Adult ID Waivers

What are the DDS Adult ID Waivers?

- The Department of Developmental Services (DDS) Home and Community Based Services Waivers are a way for individuals to receive services in their home instead of an institution.
- DDS offers three Home and Community Based Waivers for Adults with Intellectual Disabilities (ID):
  - **Adult Supports Waiver** provides services to individuals who meet the eligibility criteria and require at least one home and community-based waiver service per month.
  - **Community Living Waiver:** provides services to individuals who meet the eligibility criteria and require at least one home and community-based waiver service per month. These individuals require more support than those in the Adult Support Waiver, but less than those in the Intensive Support Waiver.
  - **Intensive Supports Waiver** provides services to individuals who meet the eligibility criteria and require supervision and support 24 hours a day, seven days a week due to significant behavioral, medical and/or physical support needs.

Who is eligible to participate in this program?

- For individuals to be eligible for the DDS Waivers, they must meet the following Federal Waiver requirements:
  - Be a person with an intellectual disability as determined by DDS;
  - Be at least 22 years of age or older;
  - Be financially eligible;
  - Be eligible for admission to an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID);
  - Agree to receive services in the community rather than an institution; and
  - Be assessed by DDS to need one or more Waiver services.

For ASAP Utilization. Do not Distribute

DDS/CTLP Transition Coordination

Note: CTLP staff will not refer for these waivers. For individuals confirmed by DDS as having Intellectual Disabilities through the PASRR process, DDS will support the waiver application process and if determined eligible, may seek CTLP team support for individuals with complex discharges.

DDS Adult ID Waivers

What additional information about the program is available?

- DDS HCBS Waiver Brief
  - https://www.mass.gov/doc/dds-hcbs-waiver-brief/download
- DDS Website
  - https://www.mass.gov/lists/dds-home-and-community-based-services-hcbs-waiver#dds-hcbs-waiver-applications-
- Choosing the Best Waiver Service
  - https://www.mass.gov/doc/choosing-the-best-waiver-service/download

How do I make a referral or submit an application?

- N/A – The DDS service coordinator will be supporting the consumer's transition.

Are there any timing considerations for when to submit an application?

- N/A. Applications to participate in the program may be submitted **at any time** by DDS.

What is the process after an application is submitted?

- DDS will conduct an assessment of the individuals needs and determine if they meet the eligibility requirements.

If I have questions about my consumer's application, who do I contact?

- Contact DDS at 888 367 4435.

What types of support might I be asked to provide during transition to the community?

DDS Service Coordinators may seek support from CTLs for individuals with complex discharges.

For ASAP Utilization. Do not Distribute

DMH/CTLP Transition Coordination

Recovery Learning Community (RLC)

What is a Recovery Learning Community?

Recovery Learning Communities (RLCs) are peer-run networks of self help/peer support, information and referral, advocacy and training activities. Training in trauma-healing, recovery concepts and tools, advocacy forums and social and recreational events are all part of what goes on in a Recovery Learning Community.

The doors are open to all people who are struggling with their mental health or who are looking for peer-to-peer support. RLCs work collaboratively with mental health providers, other human service agencies and the community at large to forward the mission of community integration and respect for people with mental health conditions. RLC activities are designed to appeal to the range of people in the community, including people of all racial and ethnic backgrounds and people of all co-occurring disabilities. **RLCs are for everyone.**

There are 5 RLCs in MA:

1. Central: Kiva Centers; https://kivacenters.org
2. Western: Wildflower Alliance; https://wildfloweralliance.org
3. Northeast: Northeast RLC; www.nilp.org
4. Metro Boston: Metro Boston Recovery Learning Community; https://www.mbrlc.org/
5. Southeast: Southeast RLC (SERLC); www.southeastrlc.org

Who is eligible to participate in these programs?

- Anyone who identifies with having a Mental Health condition is eligible to participate.
- RLCs provide in-person and virtual peer support, wellness groups, and discussion groups for those looking to learn and interact with mental-health peers and is **best for someone who does not need a lot of structure or hands-on assistance**.

How do I make a referral or submit an application?

- RLCs do not require a referral.
- People interested in peer-to-peer supports may drop into the centers or attend virtual events at any time the center is open.
- CTLPs may consider offering a copy of the calendar of events of the RLC specific to their area to a person who is interested.
- If CTLPs call on behalf of a person who's interested in an RLC, it is most welcome with the person directly present during the call or CC'd in the email contact.

For ASAP Utilization. Do not Distribute

DMH/CTLP Transition Coordination

Clubhouse

What is a Clubhouse?

Clubhouse Services provide skill development and employment services that help individuals develop skills in social networking, independent living, budgeting, accessing transportation, self-care, maintaining educational goals, and securing and retaining employment. Network of Care Massachusetts provides a full listing of Massachusetts' 35 Clubhouses: https://massachusetts.networkofcare.org/mh/index.aspx

Clubhouse members contribute to the operation of the Clubhouse and various ways including preparing meals, answering phones, cleaning, creating newsletters, or interviewing for new staff.

People in a NF may attend a Clubhouse while in the facility.

Who is eligible to participate in these programs?

- Consumers must meet clinical eligibility to participate in a Clubhouse:
  - Have a DMH qualifying diagnosis that limits one or more major life functions
  - Meet criteria of having a mental illness
  - Do not need to be DMH service authorized
- Clubhouses **do not provide hands-on assistance.**
- Questions related to appropriateness of clubhouse services can be addressed with the Clubhouse Program Director (clubs can be contacted through the Network of Care)

How do I make a referral or submit an application?

- Each agency that runs a Clubhouse has their own referral form and intake process
- The CTL should talk with the Clubhouse to confirm it matches the consumer's needs and preferences

For ASAP Utilization. Do not Distribute

DMH/CTLP Transition Coordination

Clubhouse

What additional information about the program is available?

- The Massachusetts Clubhouse Coalition website provides a full listing of Massachusetts' 35 Clubhouses: https://www.massclubs.org/massachusetts-clubhouses

Are there any timing considerations for when to submit an application?

No. Applications to participate in the program may be submitted at any time.

What is the process after an application is submitted?

- Once a referral is made, the consumer will visit the Clubhouse to get a tour and have lunch; they will receive an orientation which includes participating in work units to learn about what is available and decide if they want to join.
- If the Clubhouse and the person agree clubhouse services are appropriate, the Clubhouse will request DMH to authorize services.

If I have questions about my consumer's application, who do I contact?

Contact the Clubhouse director.

Will I be updated on the status of the application?

CTLs are advised to stay in contact with the Clubhouse Program Director or Member Services Coordinator for updates or to provide additional information as necessary.

If the application is approved, will I be responsible for the consumer getting to the Clubhouse?

Clubhouses may submit a HST (Human Service Transportation) request to DMH for transportation.

EOEA/CTLP Transition Coordination Overview

Frail Elder Waiver (FEW)

What are the FEW Program Services?

- The Frail Elder Waiver (FEW) is a MassHealth program and a Home and Community Based Services waiver. FEW provides access to the services and supports individuals need to live successfully in the community. Once enrolled in FEW, consumers have access to MassHealth State Plan services as well as the services listed below.

- FEW Services include:
  - Alzheimer's/Dementia Coaching*
  - Assistive Technology Devices
  - Chore
  - Companion*
  - Enhanced Technology/Cellular Personal Emergency Response System (PERS)
  - Environmental Accessibility Adaptation
  - Evidence Based Education Programs (EBPs)*
  - Goal Engagement Program
  - Grocery Shopping and Delivery
  - Home Based Wandering Response Systems
  - Home Delivered Meals
  - Home Delivery of Pre-packaged Medication
  - Complex Care Training and Oversight *(formerly SN)* /HHA /Home Safety/Independence Evaluations *(formerly OT)*
  - Homemaker / Personal Care / Supportive Home Care Aide
  - Laundry
  - Medication Dispensing System
  - Orientation and Mobility (O&M)
  - Peer Support (Certified Older Adult Peer Specialist)*
  - Respite Care:
    - Adult Foster Care
    - Hospital
    - Rest Home
    - Skilled Nursing Facility
    - Assisted Living Residence
    - Adult Day Health
  - Supportive Day Program
  - Transitional Assistance*
  - Transportation
  - Virtual Communication and Monitoring (VCAM)

* Indicates services are also available telephonically

EOEA/CTLP Transition Coordination Overview

Frail Elder Waiver (FEW)

Who is eligible to receive services through FEW?

- To qualify for FEW an individual must be:
    - A MassHealth member or applicant
    - Either be 60-64 years of age and have a disability, or 65 years of age or older
    - Meet clinical requirements
    - Need FEW services
    - Be able to be safely served in the community within the terms of FEW, and
    - Meet the financial requirements to qualify for MassHealth Standard in the community. Special financial rules exist for waiver applicants and participants.
- An individual must not be participating in another waiver program.
- To continue to be eligible for FEW, the consumer must receive at least one waiver service each month.
- FEW participants aged 65 and older are eligible to enroll in a Senior Care Options (SCO) plan. FEW participants who are enrolled in SCO have access to all waiver services and all services offered by the SCO plan in which they are enrolled. Enrollment in SCO is voluntary. If a FEW participant disenrolls from their SCO plan, they will continue to have access to FEW services.
- Participants in FEW may reside in their own home or apartment or in the home or apartment of a family member or caregiver. Participants in FEW may also reside in Congregate Housing. Participants in FEW cannot reside in residential settings such as Assisted Living Residences and Rest Homes or in institutional settings such as nursing facilities, except for brief periods when receiving respite services.

What additional information about the program is available?

- FEW Website: https://www.mass.gov/info-details/frail-elder-waiver-information-for-applicants-and-participants

How do I make a referral for FEW?

- Referrals for FEW are made through ASAPs.
    - If the consumer will be living **in your ASAP region**, follow your ASAP's internal business practice for initiating a referral – this may be an A&R through A&D.
    - If the consumer will be living **in a different ASAP region**, call the receiving ASAP and make a warm transfer (follow the ASAP transfer protocol).

For ASAP Utilization. Do not Distribute

EOEA/CTLP Transition Coordination Overview

Frail Elder Waiver (FEW)

Are there any timing considerations for when to make a referral?

No. Referrals to the program may be submitted at any time.

What is the process after a referral is made?

FEW requires a clinical assessment and MassHealth eligibility determination.

- The ASAP RN will complete the Level of Care (LOC) determination for clinical eligibility and the MassHealth MEC will complete the financial eligibility determination.
- The CTL can assist the consumer in completing the appropriate MassHealth forms or identify another program to assist.
- Once the consumer is discharged, best practice is to send the ASAP's LOC determination, the SC1 (status change/discharge) form from the NF, and the MassHealth enrollment application or SACA (if needed) to the MEC.

If I have questions about my consumer's application, who do I contact? Will I be updated on the status of the application?

- CTLs can contact the MEC with questions about the status of applications.
- CTLs will be notified when the consumer's FEW application is approved, if they identify themselves on the Permission to Share Information Form (PSI).

What is the process once my consumer is ready to be discharged?

- A CTL must work with the ASAP and individual to develop a service plan and submit all required forms upon discharge so that the individual may be fully enrolled in FEW.
- FEW approval will not be made until the consumer is discharged to the community.
- Prior to discharge, the nursing facility will make referrals for services and equipment needed in the home.
    - CTLs may look at MFP demo to see what services may be leveraged.
- CTLs will engage the nursing facility staff to coordinate discharge planning. CTLs may request a meeting with the nursing facility staff at any time during the process.

Will I be leading the transition to the community, or will another agency be doing this?

- Yes. CTLs will lead the transition to the community along with support from the consumer's nursing facility or other ASAP staff.

For ASAP Utilization. Do not Distribute

EOEA/CTLP Transition Coordination Overview

Home Care Services

What services are provided through the Home Care program?

- EOEA offers Home Care services in the community to assist with personal care and other activities such as housekeeping, grocery shopping and meal preparation.
- Services include:
  - Adult Day Health Program
  - Alzheimer's Day Program
  - Alzheimer's/Dementia Coaching*
  - Assistive Technology Devices
  - Behavioral Health (Diagnostic Services / Individual Therapy / Couple/Family Therapy / Group Therapy/ Case Consultation / Emergency Services / Reevaluation)
  - Bill Payer / Representative Payee
  - Chore
  - Companion*
  - Competency Evaluation
  - Electronic Comfort Pets (ECP)
  - Emergency Response Products with Fall Detection Feature
  - Emergency Shelter
  - Enhanced Technology/Cellular Personal Emergency Response System (PERS)
  - Financial Consultation
  - Fiscal Intermediary (FI)
  - Environmental Accessibility Adaptation
  - Evidence Based Education Programs (EBPs)*
  - Goal Engagement Program
  - Grocery Shopping and Delivery
  - Home Based Wandering Response Systems
  - Home Delivered Meals
  - Home Delivery of Pre-packaged Medication
  - Home Health Complex Care Training and Oversight *(formerly SN)* /HHA /Home Safety/Independence Evaluations *(formerly OT)*
  - Homemaker / Personal Care / Supportive Home Care Aide
  - Laundry
  - Legal Services
  - Medication Dispensing System
  - Nutrition Assessment
  - On Call
  - Orientation and Mobility (O&M)
  - Peer Support (Certified Older Adult Peer Specialist)*
  - Personal Emergency Response System (PERS) Enhanced PERS (EPERS)
  - Respite Care:
    - Adult Foster Care
    - Hospital
    - Rest Home
    - Skilled Nursing Facility
    - Assisted Living Residence
    - Adult Day Health
  - Supportive Day Program
  - Transitional Assistance*
  - Translation/Interpreting
  - Transportation
  - Virtual Rehabilitation
  - Virtual Communication and Monitoring (VCAM)
  - Wanderer Locator

* Indicates services are also available telephonically

Who is eligible to receive Home Care services?

- To qualify for Home Care Services an individual must:
  - Either be 60 years of age or older, or younger than 60 years of age with a physician's documented diagnosis of Alzheimer's Disease, or a related disorder such as dementia
  - Reside in Massachusetts
- Home Care Program Services **are not** provided to individuals residing in a Certified Assisted Living Residence, hospital, clinic, or infirmary; a convalescent home, rest home, nursing facility or charitable home for the aged or other facility.

For ASAP Utilization. Do not Distribute

EOEA/CTLP Transition Coordination Overview

Home Care Services

What additional information about the program is available?

- Home Care Services Website: https://www.mass.gov/service-details/home-care-services

How do I make a referral for Home Care services?

- Referrals for Home Care Services are made through ASAPs.
  - If the consumer will be living **in your ASAP region**, follow your ASAP's internal business practice for initiating a referral – this may be an A&R through A&D.
  - If the consumer will be living **in a different ASAP region**, call the receiving ASAP and make a warm transfer (follow the ASAP transfer protocol).

Are there any timing considerations for when to make a referral?

No. Referrals to the program may be submitted at any time.

What is the process after a referral is made?

- After the referral, the consumer will have an intake completed by the ASAP. This is the initial eligibility assessment that includes a Needs Assessment and a Financial Assessment. This could be completed by the CTL, depending on the ASAP business practice.
- Prior to discharge, the consumer will complete an Applicant Consent and Disclosure Form (ACD). The CTL may help with this process
- Upon discharge, the Home Care Care Manager (from ASAP) will complete a home environmental assessment and create the referrals to the service providers according to ASAP business practice.

Will I be leading the transition to the community, or will another agency be doing this?

- Yes, CTLs will collaborate during the transition to the community along with support from the consumer's nursing facility or other ASAP staff.

For ASAP Utilization. Do not Distribute

MFP Demo/CTLP Transition Coordination

Money Follows the Person Demonstration (MFP Demo)

What is the Money Follows the Person Demonstration?

- The Money Follows the Person Demonstration (MFP Demo) is a federally funded grant that covers services that help people with disabilities and older adults to move from qualified nursing facilities and long term stay hospitals to qualified residences in the community.
- MFP Demo services include:
  - Case Management
  - Assistive Technology
  - Transitional Assistance
  - Community Engagement Navigation
- For details visit the MFP Demo page at:
  - https://www.mass.gov/money-follows-the-person-demonstration

What are the MFP Demo Qualifying Criteria?

- To qualify for the MFP Demo an individual must:
  - be living in a qualified nursing facility or long-stay hospital for at least 60 consecutive days, including Medicare rehabilitation days;
  - be 18 years old or older and be disabled (disabled as defined in Title XVI of the Social Security Act and MassHealth regulation 130 CMR 501.000), OR be age 65 or older;
  - be eligible for MassHealth Standard or CommonHealth and whose last day in the facility is a Medicaid-paid inpatient day;
  - be a resident of Massachusetts;
  - have signed the Informed Consent Form; and
  - transition to an MFP Demo qualified residence in the community.

For ASAP Utilization. Do not Distribute

MFP Demo/CTLP Transition Coordination

Money Follows the Person Demonstration (MFP Demo)

How are individuals identified as potential candidates for the MFP Demo?

- Individuals who are currently and/or potentially eligible for HCBS Waivers, State Funded Home Care or MassHealth LTSS may qualify.

How do I make a referral to the MFP Demo?

- Individuals who are residing in a qualified facility and are interested in transitioning to the community or want to learn more about community services can sign up for the MFP Demo at any time.
- If the individual is currently working with MRC, DDS, and/or EOEA (if known), they should contact their case manager/service coordinator to learn more about the MFP Demo.
- **If the individual is NOT currently working with MRC, DDS, and/or EOEA**, a referral form (found on the MFP Demo website) can be completed and emailed to the MFP Demo Project Office at MFP@Mass.gov
- Once a referral is received, someone from one of the state agencies, will contact the person submitting the form and/or the applicant to explain the next steps.

Are there any timing considerations for when to submit a referral?

- No. A referral may be submitted at any time. However, to qualify, residents need to be in the facility for at least 60 days.

What is the process after a referral is submitted?

- A case manager or service coordinator will work with the individual regarding MFP Demo services and transition planning. The case manager or service coordinator may reach out to the CTLP team if needed.

If I have questions about the MFP Demo, who do I contact?

- MFP Project Office: MFP@mass.gov or 617-573-1647

Will I be updated on the status of the referral submitted to MFP Project Office?

- CTLs may reach out to the MFP Project Office to check on status of a referral.

For ASAP Utilization. Do not Distribute

MFP Demo/CTLP Transition Coordination

Money Follows the Person Demonstration (MFP Demo)

What is the process once a consumer has enrolled in the MFP Demo?

The assigned MFP Demo case manager/service coordinator:

- Enters MFP Demo enrollee information into MFP-IS
- Resolves outstanding financial eligibility issues
- Conducts intake, assessment and explores housing options
- Identifies, authorizes and monitors pre-transition services, which may include housing search, community engagement navigation (CEN), and transitional assistance
- Completes risk assessment and individualized 24/7 back-up plan prior to transition
- Facilitates development of a transition plan, which may include home and community-based waiver services (HCBS), state plan services, and MFP Demo services
- In instances where a new ASAP case manager is assigned prior to transition, the current case manager ensures there is a warm transfer to the new case manager and ensures that all services and supports are in place prior to the transition.

Will I be leading the transition to the community, or will another agency be doing this?

- The assigned case manager is responsible for all pre-transition activities.

How might I be helpful to the consumer once they have enrolled in the MFP Demo if I am not the assigned MFP Demo case manager?

- CTLs will work collaboratively with the assigned case manager.

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Acquired Brain Injury Non-Residential (ABI-N) and Moving Forward Plan Community Living (MFP-CL) Waivers

What are the ABI-N and MFP-CL Waivers?

- These **home and community-based service (HCBS)** programs are designed to transition eligible adults from nursing facilities, chronic or rehabilitation hospitals and psychiatric hospitals to qualified community settings and to furnish home or community-based services to the waiver participants following their transition from the medical facility setting.
- These waivers are for adults who can move to their own home or apartment or to the home of someone else and receive services in the community.

Who is eligible to participate in these programs?

- **The ABI-N Waiver** is available to individuals who have been living in a nursing facility, or a chronic disease, rehabilitation, or psychiatric hospital for **at least 90 days and have an Acute Brain Injury (ABI).** Specifically, an individual must:
    - **Have experienced an acquired brain injury at age 22** or older. An acquired brain injury can result from a stroke, brain trauma, infection of the brain (such as encephalitis), brain tumor, or anoxia (lack of oxygen)
    - Meet financial eligibility requirements
    - Require a facility level of care (LOC)
    - Have an ongoing need for, and receive waiver services at least once a month
    - Be able to be safely served in the community with available waiver and MassHealth State Plan services
- **MFP-CL Waiver** is available to individuals who have been living in a nursing facility, or a chronic disease, rehabilitation, or psychiatric hospital for at lease 90 days. Specifically, an individual must:
    - **Either be 18 years of age or older and have a disability, or be 65 years of age or older**
    - Meet financial eligibility requirements
    - Require a facility level of care (LOC)
    - Have an ongoing need for, and receive waiver services at least once a month
    - Be able to be safely served in the community with available waiver and MassHealth State Plan services

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Acquired Brain Injury Non-Residential (ABI-N) and Moving Forward Plan Community Living (MFP-CL) Waivers

What additional information about the program is available?

- ABI-MFP Participant Handbook
- Brochures are available in English, Spanish, Chinese, Haitian-Creole, Portuguese and Vietnamese

How do I make a referral or submit an application?

- Applications are available in English and Spanish online:
  - ABI: https://www.mass.gov/info-details/acquired-brain-injury-abi-waivers#about-the-program-;
  - MFP: https://www.mass.gov/doc/application-for-home-and-community-based-services-waivers-for-moving-forward-plan-mfp-0/download
- **CRITICAL STEP**: Complete the section of the application that asks for the name and contact information of the CTL working with the consumer to allow communication with CTLP by UMASS and program case managers (once the consumer is eligible).

Are there any timing considerations for when to submit an application?

No. Applications to participate in the program may be submitted **at any time during a facility stay.** However, consumers will not be eligible to receive waiver services if they are discharged prior to being in the facility for 90 days.

What is the process after an application is submitted?

- The ABI or MFP Waiver Unit reviews and follows up on applications to determine clinical eligibility.

If I have questions about a consumer's application, who do I contact?

- UMASS ABI Waiver Unit (ABIinfo@umassmed.edu); or 1-866-281-5602 (TTY: 1-800-596-1746)
- UMASS MFP Waiver Unit (MFPinfo@umassmed.edu); or call 1-855-499-5109 (TTY: 1-800-596-1746)

Will I be updated on the status of the application?

- Yes, if you are listed on the waiver application as an authorized representative.
- Your consumer may choose for you to be an authorized representative to help them with their application. They can do this by completing a MassHealth Authorized Representative Designation Form or from the ABI Waiver Unit.
- The CTL will be notified when the consumer is in the community if you provided your contact information on the application.

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Acquired Brain Injury Non-Residential (ABI-N) and Moving Forward Plan Community Living (MFP-CL) Waivers

What types of support might I be asked to provide during the application process?

UMASS may reach out to the CTL regarding support:

- To confirm the consumer's ability to make their own healthcare decisions or require a health care proxy or guardian.
- To collect information or signatures required for necessary forms, releases or other required information related to the MassHealth application (Application for Health Coverage for Seniors and People Needing Long-Term-Care Services or SACA).

What is the process once a consumer is determined eligible for the program?

- You will make a warm hand-off to the waiver transition coordinator.
- You will close the consumer's enrollment record in A&D and indicate that they were discharged to the waiver program.
- You may continue to support the consumer if the transition coordinator requests assistance.

Will I be leading the transition to the community, or will another agency be doing this?

- No. A waiver transition coordinator from MRC will be assigned to help the person transition to the community. They may seek out CTL assistance if the consumer needs services in the community that are not available through the waiver program.

How might I be helpful to the consumer once they are determined eligible if I am not the lead on the transition? (on demand discharge support)

- The waiver transition may seek out your assistance if the consumer needs services in the community that are not available through the waiver program.

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Supported Living (SL) Program and Supported Living Expansion Program

What are the MRC Supported Living (SL) Programs?

- These programs **provide ongoing services** for adults to **live independently in the community** and are designed to support people living with **severe physical disabilities in combination with a secondary disability** OR people living with **a behavioral health diagnosis in combination with a secondary disability**.
- The programs offer services including:
  - Assisting in managing PCA program (providing surrogacy), medication, health, finances, household, transportation
  - Requesting adaptive equipment
  - Accessing educational, vocational, social & recreational opportunities
  - Self-advocacy
  - Peer & Behavioral Supports
  - Maintaining accessible housing or assisting in identifying new housing

Who is eligible to participate in this program?

- <u>**Both The SL and SL Expansion programs**</u> are available to Massachusetts residents:
  - **Not** receiving comparable services through another state agency (DDS, DMH) or MRC Community Based Services (Waiver or SHIP).
  - Able to handle the emotional stresses of community living with reasonable supports
  - Able to be their own guardian
- <u>**The SL Program**</u> is available to individuals:
  - Living with a severe physical disability
  - Living with a secondary (sensory, cognitive, or emotional) disability which significantly impedes the individual's ability to manage their day-to-day life.
- <u>**The SL Expansion Program**</u> is available to individuals:
  - Living with a behavioral health diagnosis

MRC/CTLP Transition Coordination

Supported Living (SL) Program and Supported Living Expansion Program

What additional information about the program(s) is available?

- MRC Supported Living Programs Website , PCA Program Directory

How do I make a referral or submit an application?

- Applications for Supported Living Program may be submitted through the MRC Connect Application portal at https://massmrc.hylandcloud.com/customcode/mrconemrc
- The application has a "other" box to indicate the CTL as the referral source, including first, last name, and contact information; this will ensure the MRC eligibility screener reaches out for further assistance, if needed.
- Referrals for the SL Expansion Program may be submitted using the SLX Screening Tool

Are there any timing considerations for when to submit an application?

- No. Applications to participate in the program may be submitted at any time.

What is the process after an application is submitted?

- For SL Program - Eligibility will be determined by the MRC eligibility screener, and then reviewed by a supervisor for final determination.
- For SL Expansion – referral will be sent by MRC to SL provider and peer support who will work off of presumptive eligibility until full assessment completed by SL provider. Following SL assessment, MRC will make final eligibility determination. Should SLX not be the most suitable program, SL provider will work to ensure warm hand-off to program that may meet their service needs.

If I have questions about my consumer's application, who do I contact?

- MRC Connect Help Desk: 617-204-3665

Will I be updated on the status of the application?

- Yes, once the application or referral is submitted, CTLs will be provided routine updates regarding the application process and status.

What types of support might I be asked to provide during the application process?

- CTLs may be asked to track down information needed to complete the application.
- CTLs can support the application process and eligibility determination by sharing Level I and II PASRR information as well as any other on-going applications for other waiver of MFP Demo through the MRC application document upload section.

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Supported Living (SL) Program and Supported Living Expansion Program

What is the process once my consumer is determined eligible for the program?

For SL Program

- Once approved, the individual is assigned an MRC program coordinator who will facilitate provider supports. CTLs will collaborate and coordinate with the assigned MRC program coordinator.
- For regular SL services, CTLs will be asked to support the individual to submit a Provider Choice Request form that is based on capacity and available providers.
- An authorization for assessment will be sent to the individual's chosen provider. The provider will schedule an assessment with the individual within two business days.

Will I be leading the transition to the community, or will another agency be doing this?

- The individual will be assigned a SL Provider Agency service coordinator to lead transition planning. For SLX Program, Peer Supports will also be involved.
- CTLs will provide expertise and collaboration to coordinator.

How might I be helpful to the consumer once they are determined eligible if I am not the lead on the transition?

- CTLs will perform a warm hand-off to SL Provider Agency lead on any urgent needs or priority areas, including what may already be in process.
- Assistance to ensure Provider Choice Request form is filled out in a timely manner and facilitate introduction of SL Provider Agencies and peer supports (for SLX Program).
- Service coordinators may seek out your assistance as they facilitate the transition.

If I am leading the transition to the community, what are some of the activities I will be doing?

- N/A

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Statewide Head Injury Program (SHIP) and Traumatic Brain Injury (TBI) Waiver

What is the MRC Statewide Head Injury Program (SHIP) and Traumatic Brain Injury (TBI) Waiver?

The SHIP program:
- provides services to eligible people with external traumatic brain injuries.
- provides skills training, adult companions, residential services, shared living, and participation in the external traumatic brain injuries.
- supports individuals who need both short term or on-going lengths of service.

TBI Waiver is a subset program within SHIP. The waiver offers the same services as SHIP but can provide higher level services as needed.

Who is eligible to participate in this program?

- To qualify for **SHIP services** an individual must meet **all** requirements below:
    - be a resident of Massachusetts
    - have a confirmed injury to the brain caused by something **outside** of the brain (traumatic brain injury)
    - have difficulty managing everyday life since the injury due to difficulties caused by the brain injury
    - be willing and able to participate in and benefit from services
- To qualify for the **TBI Waiver** an individual must meet all requirements of SHIP above AND reside in the community at the time of application.

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Statewide Head Injury Program (SHIP) and Traumatic Brain Injury (TBI) Waiver

What additional information about the program is available?

- SHIP Program Website
  - https://www.mass.gov/service-details/statewide-head-injury-program-ship

How do I make a referral or submit an application?

- SHIP Program applications may be submitted through the MRC Connect portal.
  - https://massmrc.hylandcloud.com/customcode/mrconemrc
  - The application process will be expedited if CTL could provide support and follow-up related to application documentation collection.
- The application has "other" box to indicate the CTLP as the referral source. This will ensure the MRC eligibility screener can reach out for further assistance, if needed.

Are there any timing considerations for when to submit an application?

- No. Applications to participate in the program may be submitted at any time.

What is the process after an application is submitted?

- After the application is submitted the individual will be sent an eligibility letter.
- If approved, the letter will include their service coordination information. This service coordinator will reach out to the individual.
- If determined ineligible for services, an individual may follow-up to request a second review or submit an appeal.

If I have questions about my consumer's application, who do I contact?

- MRC Connect Help Desk: 617-204-3665

Will I be updated on the status of the application?

- Once determination has been made, CTLs will be notified via a secure email process.

What types of support might I be asked to provide during the application process?

- CTLs may be asked to track down information needed to complete the application.
- CTLs can support the application process and eligibility determination by sharing Level I and II PASRR information as well as any other on-going applications for other waivers or MFP Demo through the MRC application document upload section.

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Statewide Head Injury Program (SHIP) and Traumatic Brain Injury (TBI) Waiver

What is the process once my consumer is determined eligible for the program?

- An individual will be assigned a program coordinator, by geographic region, and the coordinator will reach out within a few days of the individual receiving their letter.
- The coordinator will complete a service needs assessment (SNA) with the individual. This SNA will result in service recommendations, and an individual service plan.

Will I be leading the transition to the community, or will another agency be doing this?

- The individual will be assigned a coordinator to lead transition planning.
- CTLs will provide expertise and collaboration to coordinator, as needed.

How might I be helpful to the consumer once they are determined eligible if I am not the lead on the transition? (on demand discharge support)

- The coordinator may seek out your assistance if they need support completing the SNA or supporting transition planning.

If I am leading the transition to the community, what are some of the activities I will be doing?

- N/A

For ASAP Utilization. Do not Distribute

MRC/CTLP Transition Coordination

Home Care Assistance Program (HCAP)

What is the MRC Home Care Assistance Program?

The Home Care Assistance Program (HCAP) is a statewide program administered by MRC for eligible individuals whose disabilities result in a need for homemaking and coordination of services to live independently in the community.

The HCAP provides needed homemaking and coordination of services to eligible individuals, age 18 through 59 with disabilities other than legal blindness.

Who is eligible to participate in this program?

- The individual is between the ages of 18 and 59
- Has a medically documented physical or mental disability that results in the individual's inability to perform essential homemaking tasks
- The provision of homemaking services is necessary for the individual to live independently in the community
- The individual and any other adults in the home where the individual resides, are unable to perform the homemaking tasks, as determined in the Homemaking Services Eligibility Assessment, due to disability or the relationship between the individual and other adults in the home; and
- The individual meets the financial criteria pursuant to 107 CMR 11.11.

MRC/CTLP Transition Coordination

Home Care Assistance Program (HCAP)

What additional information about the program is available?

- HCPAP Program Website
  - https://www.mass.gov/home-care-assistance-program-under-60
- HCAP Program Brochure
  - https://www.mass.gov/doc/home-care-assistance-program/download

How do I make a referral or submit an application?

- Applications may be submitted through the MRC Connect portal.
  - https://massmrc.hylandcloud.com/customcode/mrconemrc
- The application has a “other” box to indicate the CTLP as the referral source. This will ensure the MRC eligibility screener can reach out for further assistance, if needed.

Are there any timing considerations for when to submit an application?

- No. Applications to participate in the program may be submitted at any time.

What is the process after an application is submitted?

- After the application is submitted, the application will be reviewed by a supervisor and then assigned a case manager based on geographic area.

If I have questions about my consumer’s application, who do I contact?

- MRC Connect Help Desk: 617-204-3665

Will I be updated on the status of the application?

- N/A

What types of support might I be asked to provide during the application process?

- Eligibility is dependent on complete information including date of birth, financial documents, location, diagnosis, living situation, and community supports (ie., what other MRC programs are they also working with). CTLs may be asked to track down information needed to complete the application.

MRC/CTLP Transition Coordination

Home Care Assistance Program (HCAP)

What is the process once my consumer is determined eligible for the program?

- An individual will be assigned a case manager, by geographic region, and the coordinator will reach out within a few days.
- The case manager will arrange for an in-home assessment to make a recommendation for a service plan, which will include number of hours of service and specific tasks needed.

Will I be leading the transition to the community, or will another agency be doing this?

- No. The assigned case manager will be leading the transition.

How might I be helpful to the consumer once they are determined eligible if I am not the lead on the transition? (on demand discharge support)

- The case manager may seek out your assistance if they need support completing the application.

If I am leading the transition to the community, what are some of the activities I will be doing?

- N/A

For ASAP Utilization. Do not Distribute

Program Services Table as of August 2023

Service	ABI Residential Habilitation Waiver (DDS)	ABI Non-Residential Waiver (MRC)	MFP Residential Supports Waiver (DDS)	MFP Community Living Waiver (MRC)	Frail Elder Waiver (EOEA)	Traumatic Brain Injury Waiver (MRC)	Supported Living Program (MRC)	Supported Living Exansion Program (MRC)	Statewide Head Injury Program (MRC)	Homecare Assistance Program (MRC)
Residential Support Services										
Residential Habilitation	X		X			X				
Shared Living - 24 Hour Supports	X		X			X			X	
Assisted Living Services	X		X							
Independent Living Supports				X			X	X		
Shared Home Supports				X					X	
24-Hour Self Directed Home Sharing Support										
Person Care/IADL Supports										
Home Health Aide				X	X		X		X	
Personal Care		X		X	X		X	X	X	
Supportive Home Care Aide				X	X					
In-Home Supports/IADL										
Adult Companion		X		X	X	X			X	
Chore Service		X		X	X		X	X	X	X
Grocery Shopping and Home Delivery					X		X	X	X	X
Home Delivery of Pre-packaged Medication					X		X	X	X	X
Home-Delivered Meals					X		X	X	X	X
Homemaker		X		X	X	X				X
Individualized Home Supports							X	X	X	

For ASAP Utilization. Do not Distribute

Program Services Table

Service	ABI Residential Habilitation Waiver (DDS)	ABI Non-Residential Waiver (MRC)	MFP Residential Supports Waiver (DDS)	MFP Community Living Waiver (MRC)	Frail Elder Waiver (EOEA)	Traumatic Brain Injury Waiver (MRC)	Supported Living Program (MRC)	Supported Living Exansion Program (MRC)	Statewide Head Injury Program (MRC)	Homecare Assistance Program (MRC)
Laundry					X		X	X	X	X
Live-in Caregiver							X		X	
Community Engagement & Skills Training										
Community Based Day Supports	X	X	X	X						
Community Integration							X	X	X	
Day Services	X	X	X	X		X			X	
Supportive Day Program					X					
Evidence Based Education Programs					X					
Goal Engagement Program					X					
Individualized Day Supports									X	
Individual Support and Community Habilitation		X	X	X		X	X	X	X	
Peer Support			X	X	X			X		
Prevocational Services			X	X					X	
Supported Employment	X	X	X	X		X			X	
Transportation	X	X	X	X	X	X			X	
Therapy and Nursing										
Complex Care Training & Oversight					X		X	X	X	
Occupational Therapy	X	X	X	X	X					

For ASAP Utilization. Do not Distribute

Program Services Table

Service	ABI Residential Habilitation Waiver (DDS)	ABI Non-Residential Waiver (MRC)	MFP Residential Supports Waiver (DDS)	MFP Community Living Waiver (MRC)	Frail Elder Waiver (EOEA)	Traumatic Brain Injury Waiver (MRC)	Supported Living Program (MRC)	Supported Living Exansion Program (MRC)	Statewide Head Injury Program (MRC)	Homecare Assistance Program (MRC)
Physical Therapy	X	X	X	X						
Skilled Nursing			X	X						
Speech Therapy	X	X	X	X						
Family Support/Respite										
Alzheimer's/Dementia Coaching					X					
Family Training			X	X						
Respite		X		X	X	X	X	X	X	X
Stabilization										
Environmental Modifications and Accessibility Supports										
Assistive Technology							X	X	X	X
Assistive Technology for Telehealth					X	X				
Enhanced Technology/Cellular PERS					X					
Medication Dispensing System					X					
Home / Environmental Accessibility Adaptations (Home mods)		X	X	X	X	X	X	X	X	X
Home Based Wandering Response Systems					X					
Home Safety & Independence Evaluations					X					
Orientation and Mobility Services			X	X	X					

For ASAP Utilization. Do not Distribute

Program Services Table

Service	ABI Residential Habilitation Waiver (DDS)	ABI Non-Residential Waiver (MRC)	MFP Residential Supports Waiver (DDS)	MFP Community Living Waiver (MRC)	Frail Elder Waiver (EOEA)	Traumatic Brain Injury Waiver (MRC)	Supported Living Program (MRC)	Supported Living Exansion Program (MRC)	Statewide Head Injury Program (MRC)	Homecare Assistance Program (MRC)
Remote Supports and Monitoring										
Specialized Medical Equipment	X	X	X	X		X	X	X	X	X
Vehicle Modification				X			X	X	X	X
Virtual Communication and Monitoring (VCAM)					X					
Transitional Assistance/Individual Goods										
Transitional Assistance Services	X	X	X	X	X	X	X	X	X	
Individual Goods and Services							X	X	X	
Behavioral Supports										
Behavioral Supports and Consultation										
Community Behavioral Health Support & Navigation			X	X						
Expanded Habilitation, Education										

For ASAP Utilization. Do not Distribute