

**DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES & ADULT SPECIAL POPULATIONS**

*This policy replaces Individual Placement or Transfer and
Individual Transfer Between Placement Settings policies*

Title: Planned Residential Transition Policy

Approved By: 
Division Director

Written/Revised By: DDDS Policy & Records Committee

Date of Origin: October 2009

I. PURPOSE

To establish guidelines to facilitate successful transitions from Family Support to Community Services residential and changes from one community living arrangement to another.

II. POLICY

Decisions pertaining to services a person needs shall be based on a person centered planning process. Individuals will select their provider based on their personal choice and their ability to demonstrate that choice. Assistance may be provided by their family and/or their interdisciplinary team as needed or requested. Current vacancies shall focus on the most urgent cases as reflected on the Division of Developmental Disabilities Services (DDDS) Registry and individuals currently residing at Stockley Center who have been referred for a home in the community.

III. APPLICATION

DDDS Staff
Contracted Agency Staff

IV. DEFINITIONS

- A. Authorized Provider: An agency or Shared Living Provider that is fully authorized /approved to provide residential services for the Division.
- B. Authorization for Residential Placement Checklist – A checklist that must be completed in order for an individual to receive an authorization for residential placement letter. The checklist will ensure that the person is in the correct category of the DDDS Registry, that the person is a minimum of 18-years of age, that the ICAP has been completed and returned, and that the individual has met presumptive eligibility for the Waiver.
- C. Authorization for Residential Services Letter: A letter indicating that the individual has met the criteria for residential services and may begin exploring residential options.
- D. Change of Status (COS) – Notification of any informational (status) change that occurs regarding a DDDS eligible individual (e.g., demographics, financial, programmatic). Change of Status Form(s) shall be submitted to Health Information Management (H.I.M.) within one business day of the status change occurring.

- E. Choice – The process by which people make selections from available options. These options shall be made in the context of Division policy and all applicable state/federal laws and regulations that are intended to safeguard the person as well as the rights of others.
- F. DDDS Registry – The central database compilation of an individual’s demographics, service needs, services currently being provided, and assigned crisis indicators.
- G. Essential Lifestyles Plan (ELP) – A person centered plan developed with the person receiving services, his/her family or guardian, and other individuals providing support that outlines in detail the individual’s preferences, individual support needs, and lifestyle choice.
- H. ICAP Summary-
- I. Inventory for Client and Agency Planning (ICAP): An Assessment tool used by DDDS to determine an individual’s support needs and associated funding.
- J. Managers Placement Alert Email: An email sent by ORDM to all regional managers/supervisors alerting them of a placement and contract effective date.
- K. Office of Budget, Contracts, and Business Services – (OBCBS) The Division department responsible for managing the Division’s budget and developing/managing contracts with residential and/or day service providers.
- L. Office of Resource Development and Management (ORDM) - The Division’s department responsible for developing and managing the Division’s residential placement resources/options.
- M. Pre-Transfer Planning Conference- An initial meeting of an individual’s transferring and receiving interdisciplinary teams to assure that all necessary supports are defined and identified. Transition planning is initiated and the responsibilities for completing transfer related activities are assigned. The Pre-Transfer Planning Meeting is typically held only for persons transitioning from Stockley Center to Community Services or for other persons who have significant support needs. The Pre-Transfer Planning Meeting is held prior to the Transfer Planning Meeting and before a person moves into a new residential arrangement.
- N. Presumptive Eligibility – The process by which an individual’s Waiver packet materials are reviewed by the Family Support Supervisor prior to official submission to the Benefits Administrator to determine if the person will meet waiver eligibility.
- O. Residential/Vocational Rate Referral Request: A form submitted along with the current ICAP Summary to the Office of Budget, Contracts, and Business Services to obtain an individual’s ICAP funding rate.
- P. Support – A broad term used to refer to those methods designed to help an individual achieve a meaningful life and to function to his/her fullest capacity.
- Q. Transfer Planning Conference- A meeting of an individual’s transferring and receiving interdisciplinary teams for a person who is preparing to move to another residential arrangement.

Transfer Planning Conference (cont).-The meeting shall be held within 30 days prior to the move to assure that all necessary paperwork and transitioning issues have been completed or plans for completion have been developed.

- R. Transfer Planning Conference Summary – The document that identifies the support needs of an individual and the names of the person responsible to complete the task, in order to facilitate and enhance placement planning.

V. STANDARDS

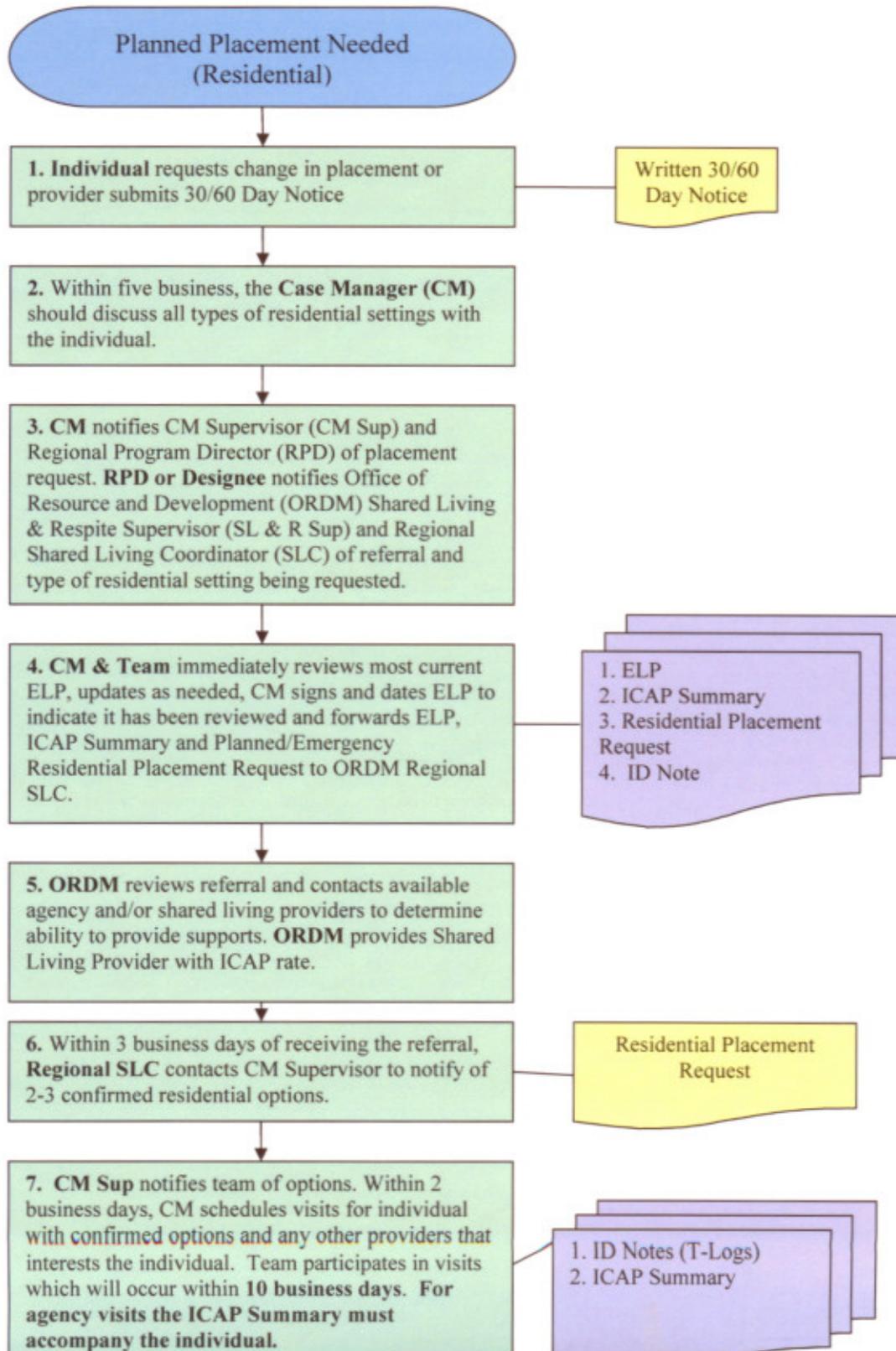
- A. Efforts shall be made to explore alternative supports/options in order to avoid disrupting an individual's life by way of and during a residential transition.
- B. DDDS shall assist individuals to explore available residential options so that they can make an informed choice.
- C. Attempts shall be made to assist individuals to visit and secure a residential option that is reflective of his/her preferences and choices and enable them to achieve their personal goals.
- D. Residential options shall promote community accessibility, comfort, and safety.
- E. Residential options shall only be considered if the provider's contractual agreement is in good standing, they are applicably licensed, certified and in compliance with DDDS standards.
- F. The following elements shall be considered during the placement process:
- Individuals' preferences and choices;
 - Family/Guardian preferences and choices;
 - Compatibility of the individual with other individuals (receiving services) and family members in the home;
 - Providers capability to meet the individual's support needs;
 - Accessibility to services and opportunities that will enhance the person's growth and satisfy their preferences;
 - Supports requested or identified by the person's Interdisciplinary Team.
 - Confidentiality
 - The availability of supports necessary to meet the person's individual needs, including clinical services.
- G. The Stockley Center Social Worker, Community Services/Special Populations Case Managers, or Family Support Specialist shall be responsible for keeping the individual and his/her relative or guardian (as applicable) informed of the progress of the placement process.
- H. If the individual is coming in from Family Support, the family shall be responsible for forwarding the individual's awarded benefit monies to the Shared Living & Respite Supervisor within 5 business days and thereafter until such time the individual returns home or the representative payee status is awarded to the DDDS. At the time of the move, the Family

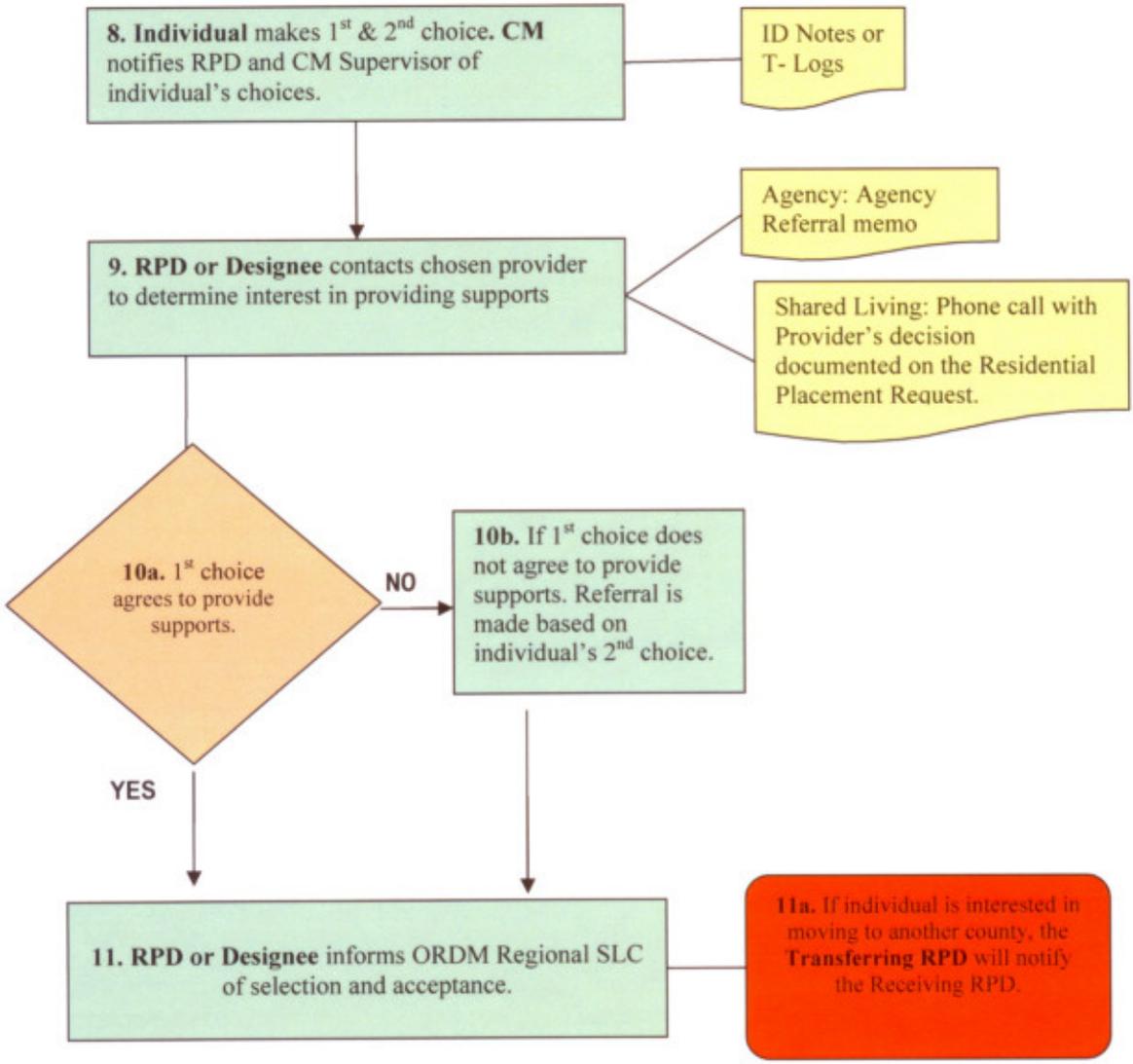
Support Specialist will provide the family with a Notice to Forward Benefits to DDDS form letter advising the family of this requirement. The family will be required to sign the letter.

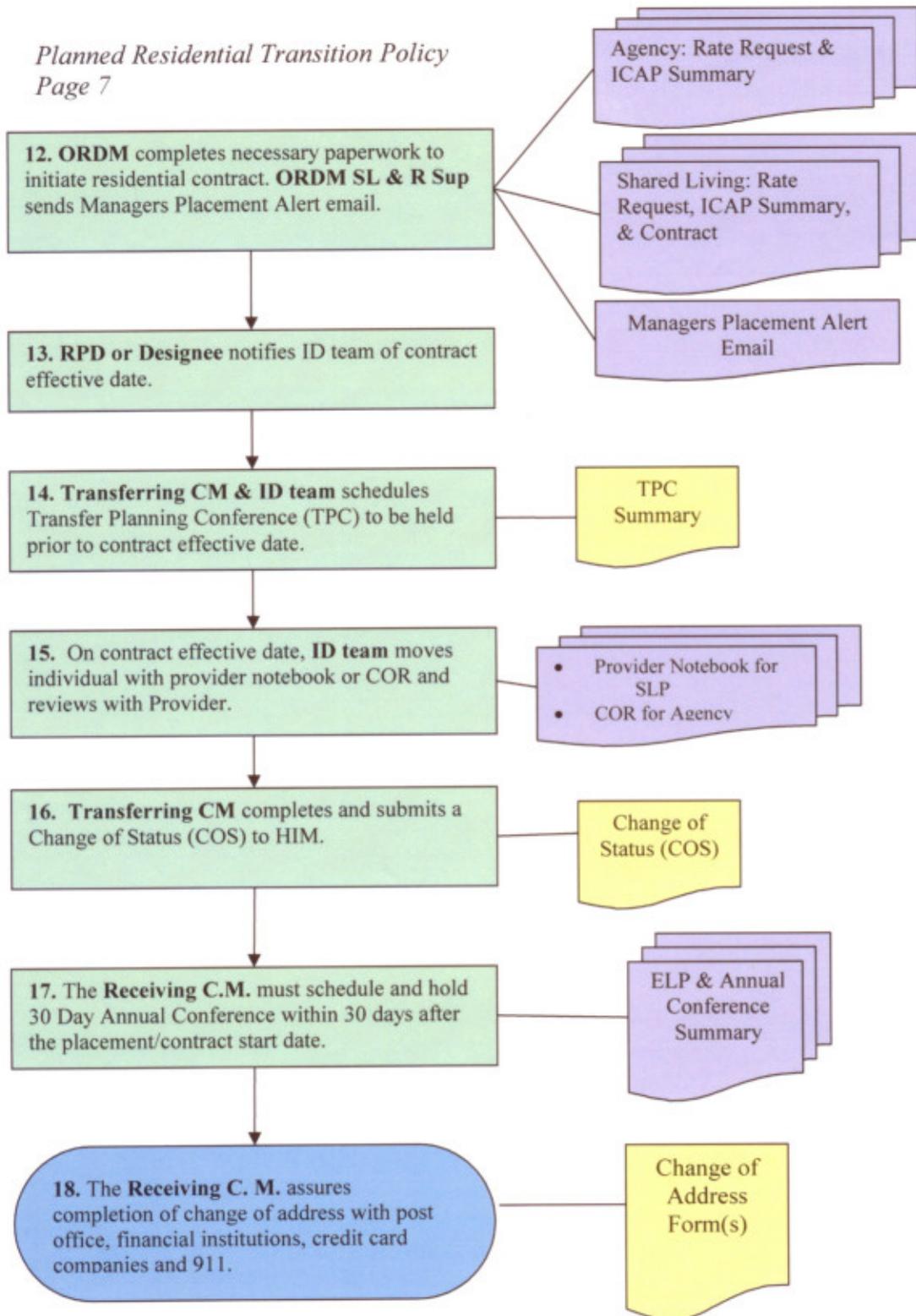
- I. Documentation shall be maintained via ID notes or T-Logs showing the individual's involvement and choice in the placement process.

VI. PROCEDURES:

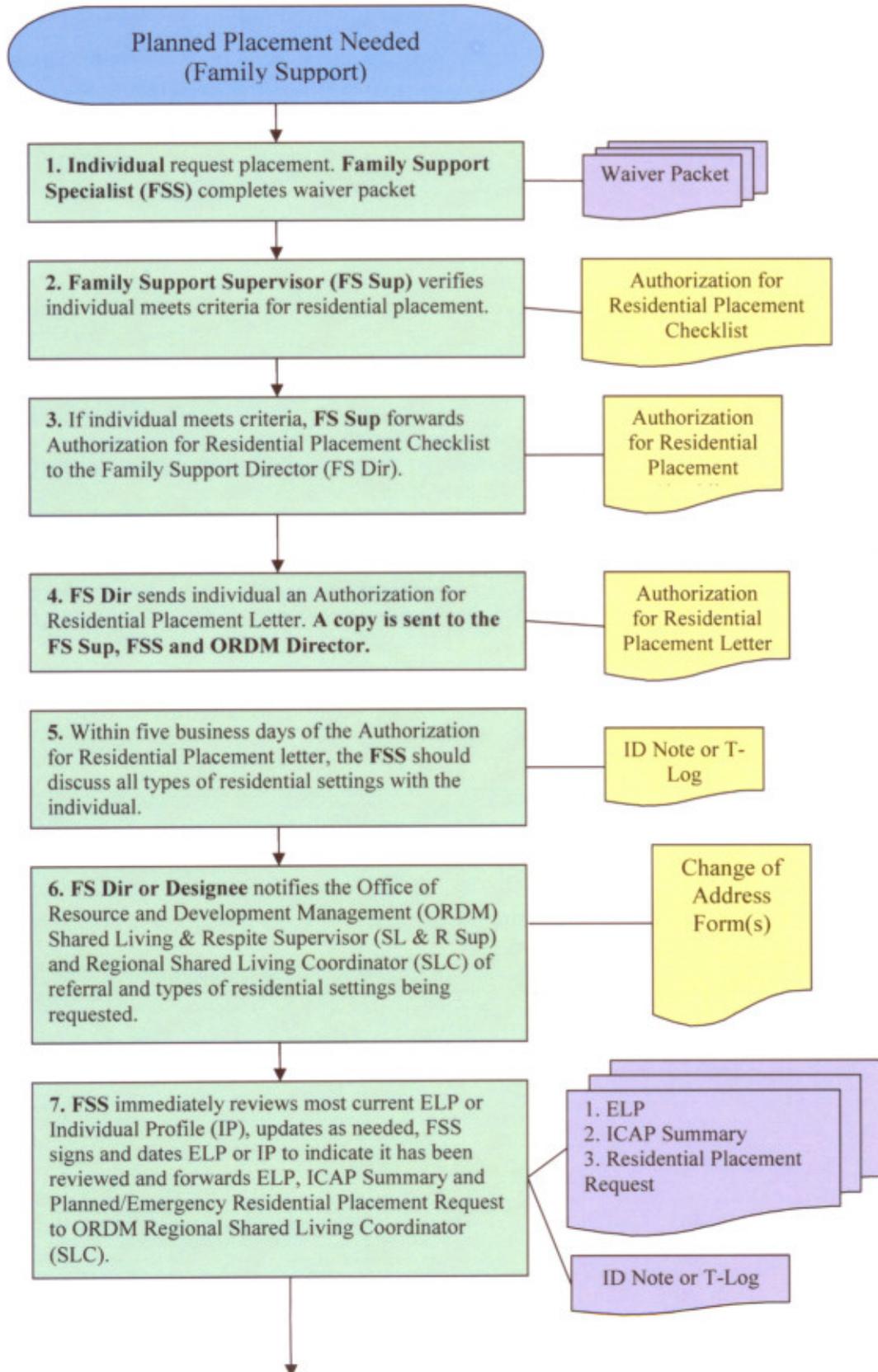
Planned Residential Transition- Change in Placement

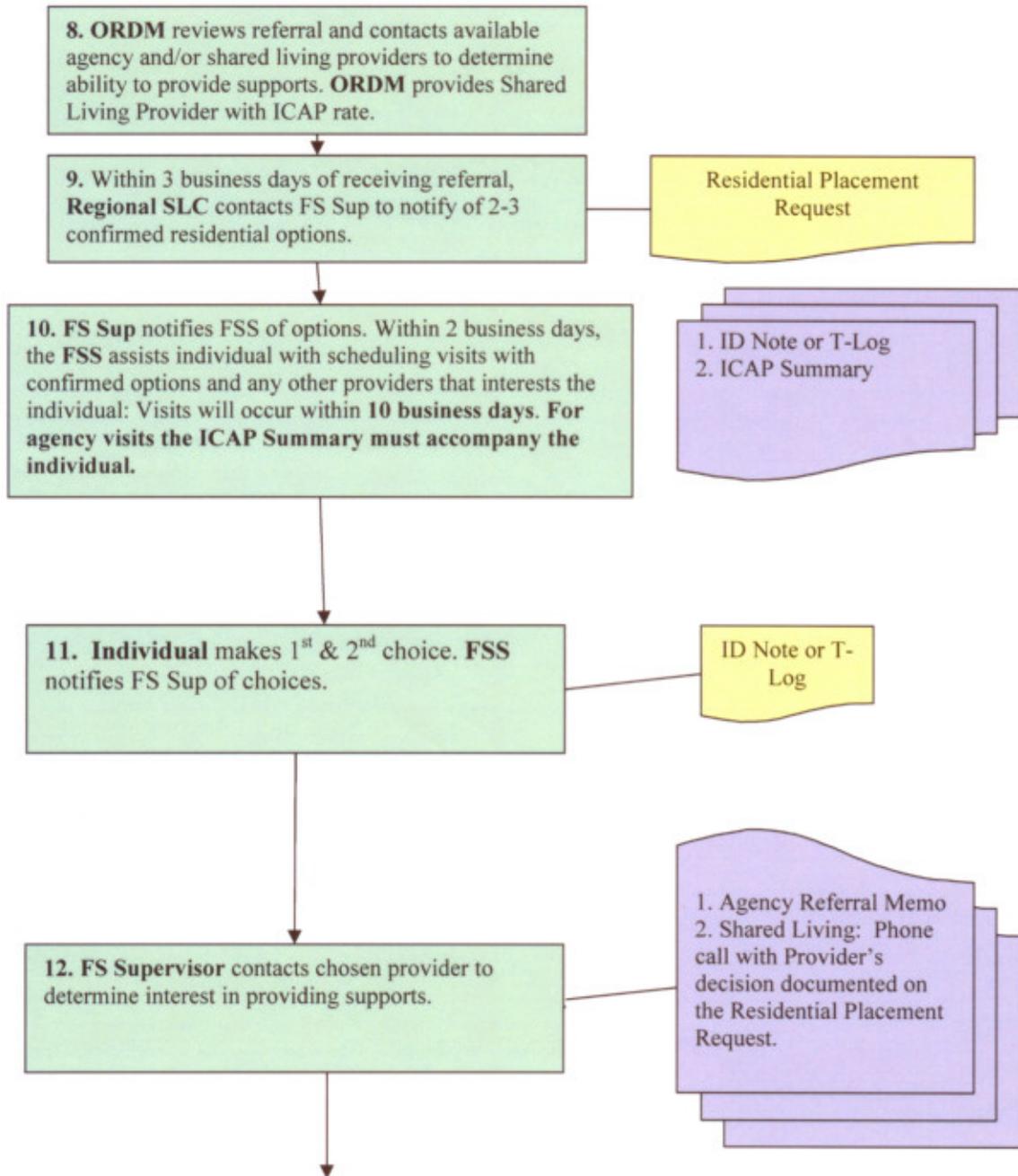


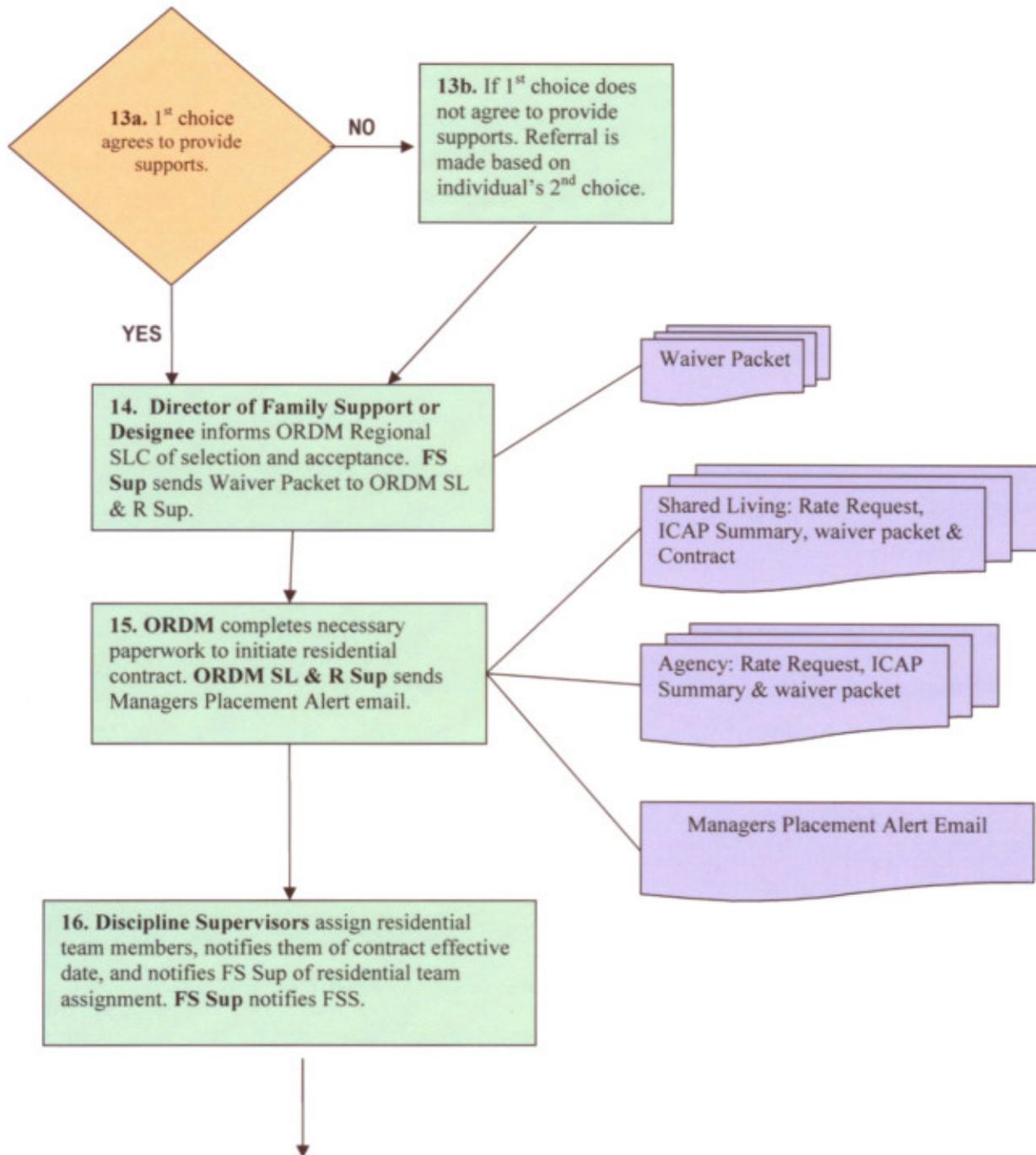


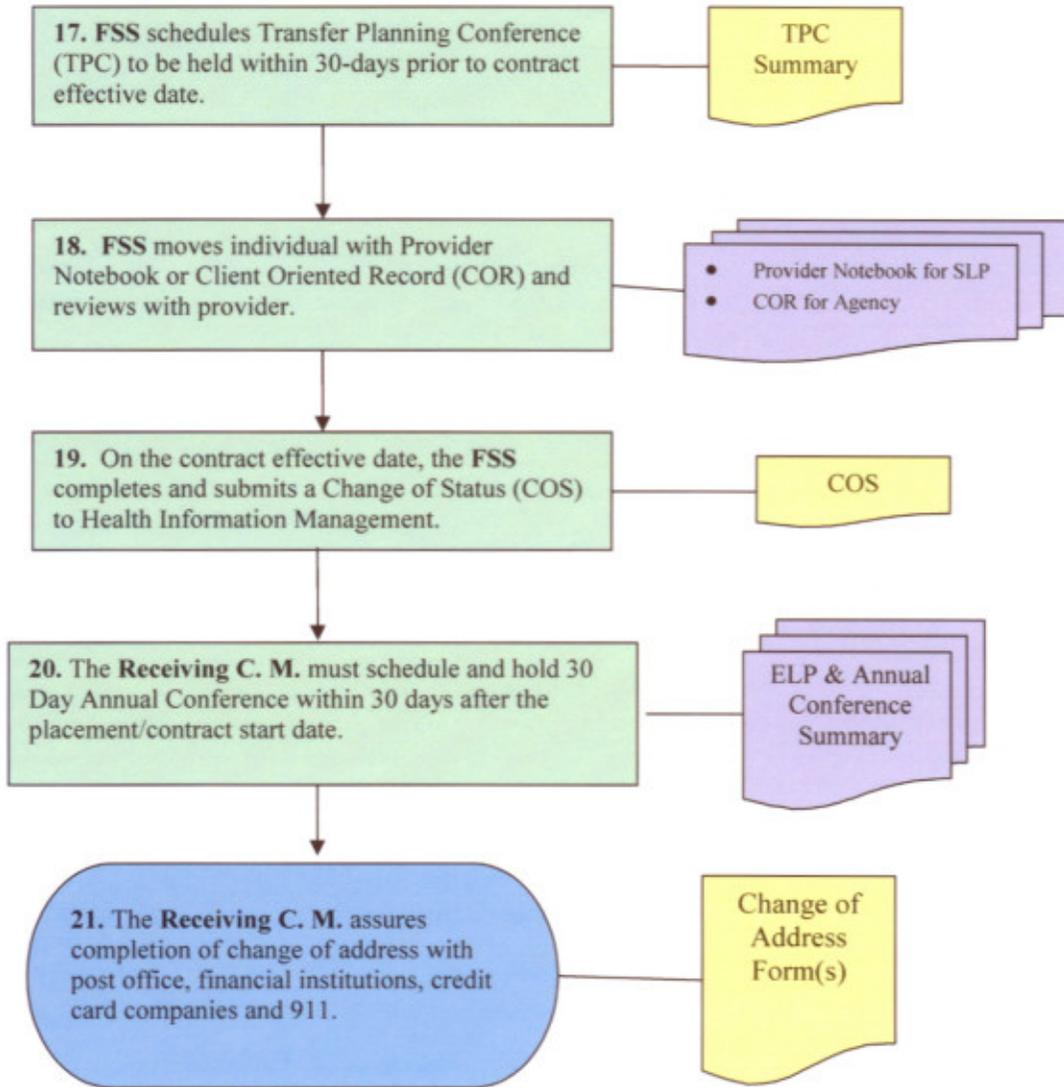


Planned Residential Transition- From Family Support









VI. SYNOPSIS

This policy establishes clear processes for residential transitions from the Family Support program to the Community Services residential program and from one CS residential placement to another. The procedural flowchart delineates the required actions steps of all involved staff as well as the applicable paperwork required at any particular time.

VII. EXHIBITS

- A. Flow Chart Shapes Defined
- B. Authorization for Residential Placement Checklist
- C. Authorization for Residential Placement Letter
- D. Transfer Planning Conference Summary
- E. Notice to Forward Benefits to DDDS form letter, 10/12/09
- F. Planned and Emergency Residential Placement Request

EXHIBIT A

FLOWCHART SHAPES DEFINED

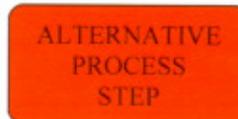
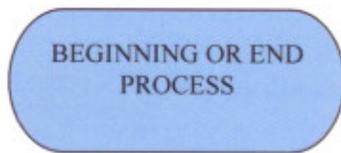
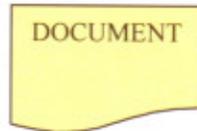
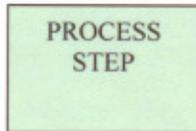




EXHIBIT B

**Division of Developmental Disabilities Services
Authorization for Residential Placement Checklist**

This checklist must be completed in order for an individual to receive an Authorization for Residential Placement Letter from the Family Support Director or the Director of Adult Special Populations. The person verifying the requirement shall sign & date the appropriate space. The checklist should be forwarded to the Family Support Director or the Director of Adult Special Populations when completed. Once completed, the Authorization for Residential Placement Letter may be issued.

Individual's Name: _____

Individual's Address: _____

REQUIREMENT	Person verifying
1. Individual is on the DDDS Registry in the correct category (Emergency or High Risk)	Family Support Supervisor: Name _____ Date _____
2. Individual is 18 years of age or older	Family Support Supervisor: Name _____ Date _____
3. ICAP has been completed and ICAP Summary returned	Family Support Supervisor: Name _____ Date _____
4. All parts of the Waiver packet including the MAP 25 have been completed, and the individual has presumptively been determined to be Waiver eligible. Note: Consultation with the DDDS Benefits Administrator may be necessary in certain cases.	Family Support Supervisor: Name _____ Date _____
5. Authorization for Residential Placement Letter generated	Family Support Dir./Dir. of Adult Special Populations: Name _____ Date _____

Sample Format Letter Containing Required Information

Date:
RE: Authorization for Residential Placement

Dear,

This letter is to inform you that you are eligible to pursue residential services from our Division. Your eligibility is limited and will be effective as of _____ and will end _____ (six months period).

You are encouraged to contact and meet residential providers so you can decide who you would like to provide you with supports. Once you have selected your agency, you will need to include an address of where you will be moving prior to placement being funded. The entire process will take an additional five weeks to secure funding once an address has been secured.

Please contact your Family Support Specialist, _____ if you have any questions or concerns.

Sincerely,

Family Support Director



**DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
TRANSFER PLANNING CONFERENCE (TPC) SUMMARY**

PERSON: _____ MCI NUMBER: _____

TPC DATE: _____ BIRTHDATE: _____

PREPARED BY: _____ TRANSFER DATE: _____

DATES OF PLANNED VISITS: _____

The person receiving services and the I.D. Team reviewed the following and determined the need for further evaluation or action. If "yes" is checked under "Further Action Required", there must be a comment.

Received Currently?			Further Action Required?		ACTION TO BE TAKEN BY WHOM & WHEN <small>(Use additional pages or back of form for additional information).</small>
ES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Case Management Services	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Clinical Services:			
<input type="checkbox"/>	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Behavior Support	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Residential Services	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Respite Services	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Day Program or Employment Services	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Adaptive Assessment/Review	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sexuality Education / Training	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Unsupervised Time	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Guardianship / Consent Issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vocational Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dental	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Self Advocacy Education / Training	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Academic Services / Supports	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations (up to date)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Self Care	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Financial Management (bank acct & ID card)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home Maintenance Skills	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Safety / Emergency Procedures	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Medical/Physical Supports for Appointments	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Getting Around the Community	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Social & Interpersonal Responsibility	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Responsibilities in Their Own Health Care	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Voter Registration / Election Activities	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Transfer Summary
Page 2 of 2

<i>Signature of those Attending</i>	<i>Print Name</i>	<i>Relationship to Person</i>
Name: _____	_____	_____

Note: Also see ELP Cover Sheet for others who have contributed.



EXHIBIT F

Planned and Emergency Residential Placement Request

Name: _____ Date: _____

Submitted by: _____

Requesting options in _____ shared living _____ agency _____ both
_____ NCC _____ Kent _____ Sussex _____ Any

Attach ICAP and ELP/profile & hand deliver, fax or email to Shared Living/Respite Supervisor

ORDM

Name: _____ Phone number _____

Comments: _____

Name: _____ Phone number _____

Comments: _____

Name: _____ Phone number _____

Comments: _____

Region

Need more options _____ Yes _____ No

Placement match confirmation (individual selects provider & provider accepts individual): _____