AGING AND DISABILITIES RESOURCE LINK (ADRL) FLEXIBLE TRANSITION AND INSTITUTIONAL DIVERSION SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES
SFN 649 (7-2023)

APPLICATION PROCESS

Referral/Application:
Send referrals/applications for ADRL Transition Service to Aging and Disabilities Resource Link at CareChoice@ND.gov or by calling 1-855-462-5465.

Incomplete applications may cause a delay in processing.

Type of Application

☐ **Transition from a group living location to the community (Complete Sections A and B)**

☐ **Assistance to avoid institutionalization (Complete Sections A and C)**

SECTION A: APPLICANT INFORMATION

Name	Date of Birth	Gender ☐ Male ☐ Female	Telephone Number
Name of Person Completing Referral	Referring Agency		Referral Telephone Number

Insurance Type

☐ Medicaid
☐ No ☐ Yes - Medicaid Number: _____

☐ Medicaid Expansion
☐ No ☐ Yes - MA Expansion Number: _____

If you do not have any form of Medicaid, have you applied for Medicaid?
☐ Yes ☐ No

Date of Application

Income Type
☐ Social Security Income
☐ Social Security Disability Insurance Income
☐ No Income
☐ Supplemental Security Income
☐ Other (specify):

Current Monthly Income

Household Size

Does this person have a significant disability?
☐ Yes ☐ No

Type of Disability

Diagnosis

What major life activities are limited by the disability?

☐ Breathing ☐ Hearing ☐ Caring for Oneself
☐ Walking ☐ Seeing ☐ Performing Manual Tasks
☐ Talking ☐ Sleeping ☐ Working
☐ Other (specify): _____
☐ None

What services will be provided in the community to address disability related needs?

Does this person have a Legal Decision Maker (LDM)
☐ No ☐ Yes - Name of LDM:

Telephone Number

LDM Type

☐ Guardianship
☐ Durable Power of Attorney for Healthcare
☐ Durable Power of Attorney for Finance
☐ Durable Power of Attorney
☐ Supported Decision Maker
☐ Other (specify): _____

SECTION B: TRANSITION FROM A GROUP LIVING LOCATION TO THE COMMUNITY

Specify if you are currently living in one of the following group living residential facilities:

- ☐ Nursing Facility
- ☐ Basic Care Facility
- ☐ Assisted Living Facility
- ☐ Homeless Shelter
- ☐ Mental Health Treatment Facility
- ☐ Domestic Violence Shelter
- ☐ Substance Use Disorder Treatment Facility
- ☐ Other (specify): _____

Name of Group Living Facility			
Address	City	State	ZIP Code
Date of Admission	Anticipated Discharge Date	Planned Discharge Location	

Type of Transition Assistance needed (needs furniture, etc.)

SECTION C: ASSISTANCE TO AVOID INSTITUTIONALIZATION

Specify if you are in direct threat of being placed in one of the following long term institutional settings:

- ☐ Nursing Facility
- ☐ ICF/ID
- ☐ Basic Care
- ☐ Assisted Living
- ☐ Other (specify):_____
- ☐ Living environment is found to be inhabitable based on an inspection from a local housing office or inspector, and their continued habitation at the residence would be dangerous
- ☐ A change in health or disability results in the need for an accessible housing unit
- ☐ Individual with a DDPM moving from a family home into the community
- ☐ Individual identified by HCBS CM as a target population member

Current Community Address	City	State	ZIP Code

Type of Assistance Needed (examples: assistive device, home modification, assistance moving to new living situation, etc.)

FOR INTERNAL USE ONLY

Date Application Received	Date Application was Approved	Type of ADRL Service Approved ☐ Transition ☐ Diversion
Date Referral Sent to the Assigned Agency	Agency Assigned to Provide ADRL Service	

Date Application was Denied	Type of ADRL Service Denied ☐ Transition ☐ Diversion

Reason(s) for Denial of **Transition** Service

- ☐ Applicant did not meet financial eligibility requirements (Medicaid, Medicaid Pending, Medicaid Expansion, federal poverty level)
- ☐ Applicant did not meet one of the follow program eligibility requirements:
  - ☐ Is not transitioning from Qualified Group Setting
  - ☐ Does not plan to transition to a Qualified Community Setting
  - ☐ Does not have a Significant Disability identified
  - ☐ Moving out of North Dakota
  - ☐ Incomplete Application

Reason(s) for Denial of **Diversion** Service

- ☐ Applicant did not meet financial eligibility requirements (Medicaid, Medicaid Pending, Medicaid Expansion, federal poverty level)
- ☐ Applicant did not meet one of the follow program eligibility requirements:
  Is not currently Living in a community setting (Apartment, Home, Mobile Home, Agency Foster Care etc.)
- ☐ Does not have a Significant Disability identified
- ☐ Did not meet one of the following requirements:
  - Direct Threat for admission to a nursing home, intermediate care facility, Assisted Living, or Basic Care facility.
  - Individual's living environment is found to be inhabitable based on an inspection from a local housing office or inspector, and their continued habitation at the residence would be dangerous
  - Change in health or disability results in the need for an accessible housing unit,
  - Moving from a living situation that poses an imminent safety risk verified by the transition provider.
- ☐ Moving out of North Dakota
- ☐ Incomplete Application

Comments