Long-Term Services and Supports Referral & Process

November 2021 (5th and 19th)
LTSS Referrals & Process

• Referrals:
  • *All* referrals *must* be submitted utilizing the SFN 584.
  • The SFN 584 can be located at:
    • [https://www.nd.gov/eforms?sfntitle=584#searchResults](https://www.nd.gov/eforms?sfntitle=584#searchResults) (*must* use Internet Explorer)
    • [https://carechoice.nd.assistguide.net/](https://carechoice.nd.assistguide.net/)
LTSS Referral & Process

- Referrals can be generated either through:
  - LTCF
  - MDS Section Q – Information Only or Wants to go Home
  - Family
  - Friend
  - Consumer
  - Physician
  - Other

- Facilities – The individual responsible for submitting Referrals to Aging Services:
  - Email (carechoice@nd.gov);
  - Submit online; and/or
  - Fax (701.328.8744)

- Families, Friends, Consumers - Submitting Referrals to Aging Services:
  - Must call the Aging & Disability Resource Link (ADRL)
LTSS - Referral & Process continue

- **Submitted SFN 584’s:**
  - Once the SFN 584 is submitted to Aging Services via the channels stated in the previous slide the ADRL Intake Specialist’s log the referral in the web-base data collection site, review funding source, and then send the referral to the right Aging Staff individual.

- **Funding Source:**
  - If the individual that is being referred is on Medicaid the SFN 584 will be sent to Jake Reuter, who will then send it on to the Center of Independent Living (CIL) staff assigned to that area. The CIL will then connect with the HCBS case manager supervisor for that area to get a case manager assigned.
  - If the individual that is being referred is on Medicaid & Medicare the SFN 584 will be sent to Jake Reuter, who will then send it to the CIL staff assigned to that area. The CIL will connect with the HCBS case manager supervisor for that area to get a case manager assigned.
  - If the individual that is being referred is on Medicare only and the financial section of the SFN 584 is filled out and meets the language stated in that section. The SFN 584 will be sent to Jake Reuter, who will then send it to the CIL staff assigned to that area. The CIL will connect with the HCBS case manager supervisor for that area to get a case manager assigned.
  - If the individual that is being referred is on Medicare only and the financial section of the SFN 584 is either left blank or is filled out but does not meet the language in the financial section. The SFN 584 will be sent to the Community Service Coordinator’s (CSC) based on where the individual would like to reside.
  - If the individual that is being referred is on Medicare only, but Medicaid is pending the SFN 584 will be sent to the CSC based on where the individual would like to reside.
  - If the individual that is being referred is private pay or any other type of insurance the SFN 584 will be sent to the CSC based on where the individual would like to reside.
LTSS - Referral & Process continue

• Nursing Facility/Discharge Planner Role:
  • Be part of the meetings when scheduled.
  • Assist in care planning.
  • Provide copies of the “Options Counseling (OC) Action Plan” to the individual along with anyone else they would like to have a copy.

• CIL and/or CSC Role:
  • Is responsible for responding to the facility.
  • Setting up dates and times for the meeting.
  • To complete the remainder of the SFN 584 to send back to the facility to provide to the individual that was seen.
  • In addition, the CSC will complete a “Options Counseling (OC) Action Plan” (SFN 1132) which will be sent back to the facility as the same time the SFN 584.
Aging Services Policy

- The CSC has five (5) business days to reach out to the facility for initial contact and to set up the visit.
- The CSC then has 10 business days to complete the visit. The visit can be done via telephone, virtual, and/or in-person. In-person visits would be the preferred method but due to the pandemic Aging Services has incorporated other means to connect and communicate. Please note that if there is communication between the facility and CSC the 10 days can be extended.
- Once the visit is complete the CSC then has five (5) business days to finish the SFN 584 and the “Options Counseling (OC) Action Plan” SFN 1132 along with sending it back to the facility.
Referrals from LTCF, MDS Section Q, Family, Friend, Consumer, and/or a Physician can trigger a SFN 584.

The SFN 584 then is either submitted online, emailed, or faxed to Aging Services.

The CIL or CSC will connect with the facility within five (5) business days.

The CIL or CSC will visit with the individual being referred and any additional family, friends, etc. they request to be part of the meeting along with the discharge planner within 10 business days.

The CSC will complete the remaining of the SFN 584 & Options Counseling (OC) Action Plan (SFN 1132). A copy will be sent to the facility within five (5) business days.
CSC Contact Information

Nicole Kieftad Johnson
(701) 253-6396
(701) 595-6766 cell
nkj@saline.nlc.gov
South Central Human Service Center
415 2nd Ave NE - Ste 201
PO Box 726
Valley City, ND 58072

Mary Benson
(701) 857-8578
(701) 595-1500 cell
mabenson@saline.nlc.gov
North Central Human Service Center
1015 South Broadway - Ste 18
Minot, ND 58701

Rene Schmidt
(701) 227-7557
(701) 595-6430 cell
rnschmidt@saline.nlc.gov
Badlands Human Service Center
1463 I-94 Business Loop East
Dickinson, ND 58601-4875

Susi Effertz
(701) 298-4420
(701) 595-6672 cell
seffertz@saline.nlc.gov
Southeast Human Service Center
2624 9th Avenue South
Fargo, ND 58103-2350

Katie Schafer
(701) 328-8787
(701) 595-6574 cell
katschafer@saline.nlc.gov
West Central Human Service Center
1237 W Divide Avenue - Ste 5
Bismarck, ND 58501-1208

Karen Hillman
(701) 795-3017
(701) 595-3054 cell
khillman@saline.nlc.gov
Northeast Human Service Center
151 S 4th Street - Ste 401
Grand Forks, ND 58201-4735

**Note:** Morton County only Kate will receive all referrals for FCAP and Skilled Facility (SNF 58184).
Please note the SFN 584 is four (4) pages and must have (9-2021) behind the SFN 584.
Options Counseling (OC) Action Plan – SFN 1132

** Please note this replaced the “Transition Plan” SFN 585.**
LCA - Referral Process continue

- LTSS Referral Form (SFN 584)

- Options Counseling (OC) Action Plan (SFN 1132)

**Please note all State SFN forms need to be opened in Internet Explorer**
Transition Services

- Money Follows the Person Grant (MFP)
- Aging & Disabilities Resource Link Transition Services (If they don’t qualified for MFP)
- Community Transition Services (If they don’t qualified for MFP)
Money Follows the Person Grant

Eligibility
- 60 days of continuous institutional stay (Hospital, Nursing Facility, Swing Bed)
- Medicaid has to pay for at least the last day of service.
- Plan to return to their own home/apartment in the community

Service
- Transition Coordination for a Center for Independent Living Center
- $3,000 or more in moving expenses
- 24-hour backup nursing services
- Rental Assistance
ADRL Transition Services

Eligibility
• Individuals with a disability of any age living in a provider operated residential situation that is transitioning back to a community residence that do not otherwise qualify for the MFP Grant or Community Transition Wavier services
• There are no income requirements for this program.
• The residential situations can include nursing facilities, basic care facilities, assisted living facilities, homeless shelters, or other COVID-19 related group living environments.

Services
• Transition Coordination to assist with return to the community by a Center for Independent Living
• Up to $1,500 in moving expenses
• Up to six months of rental assistance
Referral for Transition Services

Referrals

• Complete the SFN 584 noting a request for MFP services in the “Type of Referral” section by selecting the “Other” (Specify) box – then write in the blank space “MFP or Transition Services”
Referral for Transition Services Continue

- LTSS Referral Form (SFN 584) be located at:
  - https://www.nd.gov/eforms?sfntitle=584#searchResults (*must* use Internet Explorer)
  - https://carechoice.nd.assistguide.net/
- The SFN 548 for MFP or Transition Services only can be emailed to Jake Reuter at jwteuter@nd.gov
State Office Contact Information

Aging & Disability Resource – LINK (ADRL)
855.462.5465
carechoice@nd.gov
701.328.8744 (Fax)

Jaclyn Seefeldt
Program Administrator
701.328.4645
jseefeldt@nd.gov

Jake Reuter
MFP Grant Program Administrator
701-239-7133
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