



## TRANSITION AND DIVERSION PROGRAM (TDP)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADULT AND AGING SERVICES

SFN 649 (5-2025)

### APPLICATION PROCESS

#### **Referral/Application:**

Send referrals/applications for TDP Transition Service to Aging and Disabilities Resource Link at [CareChoice@ND.gov](mailto:CareChoice@ND.gov) or by calling 1-855-462-5465.

#### **Incomplete applications will cause a delay in processing.**

#### **Type of Application**

- ☐ **Transition Application - from a group living facility in the community (Complete Sections A and B)**
- ☐ **Diversion Application - assistance to avoid institutionalization (Complete Sections A and C)**

### SECTION A: APPLICANT INFORMATION

Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number
Email Address			
Name of Person Completing Referral	Referring Agency	Referral Telephone Number	
Race <input type="checkbox"/> White <input type="checkbox"/> Alaska Native <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other (specify): _____			
Ethnicity/Hispanic Origin - Hispanic or Latino <input type="checkbox"/> No <input type="checkbox"/> Yes, specify Hispanic/Latino Origin: _____			
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> English Second Language <input type="checkbox"/> German <input type="checkbox"/> Arabic <input type="checkbox"/> Other (specify): _____			
<b>Is the applicant currently enrolled in one of the following state services? (Check all that apply)</b> <input type="checkbox"/> Community Connect Provider <input type="checkbox"/> Developmental Disabilities Program Manager (DDPM) <input type="checkbox"/> Free Through Recovery Provider <input type="checkbox"/> HCBS Case Manager <input type="checkbox"/> 1915i Provider <input type="checkbox"/> Children's Waiver Services <input type="checkbox"/> Regional Human Service Center <input type="checkbox"/> Other (specify): _____			
Name of Service Provider Agency	Name of Case Manager	Case Manager Telephone Number	
Insurance Type <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid Expansion Medicaid/MA Expansion Number _____			
Income Type <input type="checkbox"/> No Income <input type="checkbox"/> Employment <input type="checkbox"/> Social Security Income <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Social Security Disability Insurance Income <input type="checkbox"/> Other (specify): _____			Current Monthly Income
Household Size Number of Adults: _____ Number of Children Under 18: _____		Does this person have a significant disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Disability/Diagnosis			
What major life activities are limited by the disability? <input type="checkbox"/> Breathing <input type="checkbox"/> Hearing <input type="checkbox"/> Caring for Oneself <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Walking <input type="checkbox"/> Seeing <input type="checkbox"/> Performing Manual Tasks <input type="checkbox"/> None <input type="checkbox"/> Talking <input type="checkbox"/> Sleeping <input type="checkbox"/> Working			

<b>Does this person have a Legal Decision Maker (LDM)</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - Name of LDM: _____	<b>Telephone Number</b>
<b>Address of LDM</b>	
<b>LDM Type</b> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Guardianship <input type="checkbox"/> Durable Power of Attorney for Healthcare <input type="checkbox"/> Durable Power of Attorney for Finance</div><div><input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Supported Decision Maker <input type="checkbox"/> Other (specify): _____</div></div>	
<b>Additional Information</b>	

### 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: Homeless shelters and jails do not qualify for Transition.			
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> ICF/IDD	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Basic Care Facility	<input type="checkbox"/> Medical Hospital		
<b>Name of Group Living Facility</b>			
<b>Address</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>
<b>Date of Admission</b>	<b>Anticipated Discharge Date</b>	<b>Planned Discharge Location</b>	
<b>Type of Transition Assistance needed (needs furniture, etc.)</b>			

### 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: Homelessness does not qualify for Diversion.			
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Basic Care		
<input type="checkbox"/> ICF/ID	<input type="checkbox"/> Assisted Living		
<input type="checkbox"/> 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			
<input type="checkbox"/> A change in physical health or physical disability resulting in the need for an accessible housing unit			
<input type="checkbox"/> Individual with a DDPM moving from a family home into the community			
<input type="checkbox"/> Individual identified by HCBS CM as a target population member			
<b>Current Community Address</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>
<b>Type of Assistance Needed (examples: assistive device, home modification, assistance moving to new living situation, etc.)</b>			

**FOR INTERNAL USE ONLY**

Date Application Received	Date Application was Approved	Type of TDP Service Approved <input type="checkbox"/> Transition <input type="checkbox"/> Diversion
Date Referral Sent to the Assigned Agency	Agency Assigned to Provide TDP Service	

Date Application was Denied	Type of TDP Service Denied <input type="checkbox"/> Transition <input type="checkbox"/> Diversion
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Reason(s) for Denial of **Transition** Service

☐ Applicant did not meet financial eligibility requirements (Medicaid, Medicaid Expansion, with income at or below 138% of the federal poverty level)

☐ Applicant did not meet one of the following program eligibility requirements:

- ☐ Is not transitioning from a 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

☐ Another household member has been approved for services

☐ Qualified Disability not listed or identified

☐ Have already been approved this calendar year

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

☐ Applicant did not meet financial eligibility requirements (Medicaid, Medicaid Expansion, with income at or below 138% of the federal poverty level)

☐ Applicant did not meet one of the following 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 physical health or physical disability results in the need for an accessible housing unit.
- Individual identified by HCBS CM as a target population member.

☐ Moving out of North Dakota

☐ Is not moving to a Qualified Community Residence

☐ Incomplete Application

☐ Another household member has been approved for services

☐ Qualified Disability not listed or identified

☐ Have already been approved this calendar year

Comments