NORTH DAKOTA TRANSITION AND DIVERSION SERVICES PILOT PROJECT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT AND AGING SERVICES
SFN 649 (11-2024)

Clear Fields

APPLICATION PROCESS

Referral/Application:
Send referrals/applications for TDPP 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 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 ☐ Male ☐ Female	Telephone Number

Email Address

Name of Person Completing Referral	Referring Agency	Referral Telephone Number

Race

☐ White ☐ Alaska Native ☐ Hispanic
☐ African American ☐ Native Hawaiian ☐ Asian
☐ American Indian ☐ Other Pacific Islander ☐ Other (specify): _____

Ethnicity/Hispanic Origin - Hispanic or Latino

☐ No ☐ Yes, specify Hispanic/Latino Origin: _____

Preferred Language

☐ English ☐ Spanish ☐ English Second Language ☐ German ☐ Arabic ☐ Other (specify): _____

Is the applicant currently enrolled in one of the following state services? (Check all that apply)

☐ Community Connect Provider ☐ Developmental Disabilities Program Manager (DDPM)
☐ Free Through Recovery Provider ☐ HCBS Case Manager
☐ 1915i Provider ☐ Children's Waiver Services
☐ Regional Human Service Center ☐ Other (specify): _____

Name of Service Provider Agency	Name of Case Manager	Case Manager Telephone Number

Insurance Type

☐ Medicaid ☐ Medicaid Expansion Medicaid/MA Expansion Number _____

Income Type

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

Current Monthly Income

Household Size

Number of Adults: Number of Children Under 18:

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

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

LDM Type

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

Additional Information

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.

☐ Nursing Facility
☐ Assisted Living Facility
☐ ICF/IDD
☐ Basic Care Facility
☐ Medical Hospital
☐ 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:
Homelessness does not qualify for Diversion.

☐ Nursing Facility
☐ Basic Care
☐ ICF/ID
☐ Assisted Living
☐ 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 physical health or physical disability resulting 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 TDPP Service Approved ☐ Transition ☐ Diversion
Date Referral Sent to the Assigned Agency	Agency Assigned to Provide TDPP Service	

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

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

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
- ☐ Incomplete Application
- ☐ Another household member has been approved for services

Comments