

<b>STATE OF ALASKA</b> <b>DEPARTMENT OF HEALTH &amp; SOCIAL SERVICES</b>  <b>SENIOR AND DISABILITIES SERVICES</b>  <b>POLICY &amp; PROCEDURE MANUAL</b>	<b>SECTION:</b> 3 Waivers	<b>Number:</b> 3-2	<b>Page:</b> 1
	<b>SUBJECT:</b> Care Coordinator Appointment and Transfer		
	<b>APPROVED:</b> <i>/s/ Rebecca J. Hilgendorf</i> Rebecca J. Hilgendorf, Director		<b>DATE:</b> 4/23/09

## Purpose

To give notice of care coordinator selection to all parties involved in the care of an applicant/recipient.

To delineate the responsibilities and the process for transferring care coordination services.

## Policy

To receive Medicaid funding for the Home and Community Based Waiver Services Program, the State of Alaska agrees to specified terms, including the provisions for choice in the selection of service providers and for development of individual plans of care. Accordingly, SDS affirms the right of applicant/recipients to choose a care coordinator to develop a plan of care which suits his/her needs, and the right to change care coordinators at any time and for any reason.

Care coordinators, when selected by an applicant/recipient, provide notice of appointment. In addition, when an applicant/recipient selects another to provide his/her care coordination services, the former and the new care coordinators cooperate to ensure that services continue during the transfer.

## Authorities

42 CFR §431.51 Free choice of provider; 42 CFR §440.180 (b) (1) Case management services; 42 CFR §441.301 (b)(1)(i) Written plan of care; 7 AAC §43.1041 Care coordination services.

## Definitions

Home and Community Based Waiver Services Program: the Medicaid program which includes the Adults with Physical Disabilities program, the Children with Complex Medical Conditions program, the Individuals with Developmental Disabilities program, and the Older Adults program.

Representative: a parent, guardian, or other individual with legal authority to act on behalf of a recipient.

## Responsibilities

- A. The **care coordinator** is responsible for
  1. discussing the scope of his/her services with an applicant/recipient,
  2. notifying SDS and all service providers of his/her appointment by an applicant/recipient,
  3. ensuring services during a transfer of care coordination responsibilities, and
  4. sending copies of specified materials to a new care coordinator.
  
- B. The **applicant/recipient** is responsible for
  1. selecting a care coordinator to access, plan for and monitor services, and
  2. signing the appropriate form to indicate selection.

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C. **SDS** is responsible for

1. ensuring the process of appointment and transfer is followed, and
2. reviewing transfers when concerns are submitted by care coordinators.

**Procedures**

**A. Appointment for Care Coordination Services.**

1. Appointment process. The care coordinator
  - a. discusses the services, listed on the *Appointment for Care Coordination Services* (Attachment A), he/she is responsible for providing to the applicant/recipient;
  - b. completes and signs the *Appointment* form; and
  - c. obtains the signature of the applicant/recipient or representative.
2. Distribution of forms. The care coordinator sends copies of the signed *Appointment* form
  - a. to the applicant/recipient, and
  - b. to SDS.
3. Discussion content. The care coordinator agrees to
  - a. assist the applicant/recipient with Medicaid eligibility requirements;
  - b. explain program rights to the applicant/recipient and representative, as specified in *SDS Policy 2-1 Program Rights Information for Recipients*;
  - c. develop a Plan of Care (POC);
  - d. maintain case notes;
  - e. evaluate whether recipient needs are met by making at least two contacts a month, including
    - i. one telephone contact, and
    - ii. one face-to-face visit (unless waived by SDS);
  - f. contact providers if services are unsatisfactory or not in accordance with the POC;
  - g. provide contact information for emergencies or when unavailable for over 48 hours;
  - h. give 30 days notice of termination of services; and
  - i. cooperate in the transfer of care coordination services.

**B. Transfer of Care Coordination Services.**

1. The new care coordinator
  - a. follows the appointment process in Section A to record his/her appointment, and distributes copies as indicated;
  - b. notifies the former care coordinator, within 2 working days, by sending copies of signed *Appointment* and release of information forms as attachments to an email message, by Fax, or by regular mail;
  - c. notifies all providers listed in the current POC, within 2 working days of receipt of the POC from the former care coordinator, by sending copies of signed *Appointment* and release of information forms as attachments to an email message, by Fax, or by regular mail; and
  - d. works with the former care coordinator to ensure a transition without interruption to the services outlined in the POC.

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2. The former care coordinator

- a. completes and signs the *Transfer of Care Coordination Services* (Attachment B);
- b. within 5 working days of receipt of a copy of the *Appointment* form signed by the applicant/recipient or representative, sends copies of the following materials to the new care coordinator:
  - i. current POC and POC Amendments,
  - ii. most recent assessment,
  - iii. case notes for the past 12 months, and
  - iv. additional documents or information necessary for a safe transition;
- c. sends copies of the signed *Transfer* form
  - i. to the new care coordinator; and
  - ii. to SDS; and
- d. works with the new care coordinator to ensure a transition without interruption to services outlined in the POC.

**C. Reporting transfer concerns.**

Although the recipient has a right to change care coordinators at any time and for any reason, concerns regarding a transfer may be submitted to the SDS Quality Assurance Unit, (907) 269-3666 (Anchorage) or 1-800-478-9996.

Attachments

1. Attachment A: Appointment for Care Coordination Services
2. Attachment B: Transfer of Care Coordination Services

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### Appointment for Care Coordination Services

**Recipient**

Name: CCAN:  
Plan of Care Start Date: End Date:

**Care Coordinator**

Name: CM Number:  
Telephone Number:  
Care Coordination Agency: CMG Number:

I am a certified care coordinator authorized by the State of Alaska to assist you to obtain services funded by the Medicaid Home and Community Based Waiver Services program. If you are determined to be eligible and continue to meet eligibility requirements, you will qualify for services through the Choose an item. program.

As your care coordinator, I agree:

- To assist with your initial application for and renewals of Medicaid eligibility, but it is your responsibility to complete the forms and submit them to the Division of Public Assistance with all required documentation.
- To explain your program rights and responsibilities, and to give you a copy of the *SDS Program Recipient Rights* and the *Notice of Adverse Actions, Hearings, and Appeals*.
- To assist you and/or your legal representative to develop a Plan of Care to meet your needs, to revise this plan when your needs change or are not being met, and to submit timely, on your behalf, all documents required by SDS.
- To maintain case notes (available to you upon request) documenting visits, contacts, and other matters regarding your services.
- To evaluate whether your Plan of Care is meeting your needs and whether the services approved, have been provided, through a face-to-face visit at least once a month (unless waived by SDS) and telephone contact with you or your legal representative at least once a month.
- To contact your providers when services are not provided to your satisfaction or in accordance with your Plan of Care.
- To provide contact information as to where you can reach me, with the understanding that I cannot be available to you at all times and that you should call 911 when immediate care is needed.
- To provide you with contact information for another care coordinator for assistance whenever I will be unavailable for over 48 hours.
- To provide you with 30 days notice, inform SDS, and help you to find another care coordinator if I exercise my right to terminate my services to you.
- To cooperate in the transfer of care coordination services to another if you exercise your right to change care coordinators at any time or for any reason

\_\_\_\_\_  
Signature of Care Coordinator

\_\_\_\_\_  
Effective Date of Appointment

\_\_\_\_\_  
Signature of Applicant/Recipient or Legal Representative

\_\_\_\_\_  
Date

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### Transfer of Care Coordination Services

***Recipient***

Name:  
CCAN:  
Plan of Care Start Date: End Date:

***Former Provider of Care Coordination Services***

Name: CM Number:  
Telephone Number:  
Care Coordination Agency: CMG Number:

***New Provider of Care Coordination Services***

Name: CM Number:  
Telephone Number:  
Care Coordination Agency: CMG Number:

I received an *Appointment for Care Coordination* form and a *Release of Information* form, from the above named new provider selected by the recipient, indicating that effective he/she will begin providing care coordination services. I will work with him/her to ensure a transition without interruption to the services listed in the current Plan of Care, and will coordinate with SDS for a Cost Sheet transfer.

As required by SDS, I have sent the following materials to the new care coordinator on which is within 5 working days of the notice to me of this selection.

- Copy of the current Plan of Care and POC Amendments
- Copy of the most recent assessment
- Copy of case notes for the past 12 months
- Copy of the signed Transfer form
- The following additional documents or information necessary for a safe transition:

I understand that my responsibilities end when the materials are sent, and SDS is provided with a copy of this form.

\_\_\_\_\_  
Signature of Former Care Coordinator

\_\_\_\_\_  
Date