

SUBJECT: DEVELOPMENTAL DISABILITY SERVICES
ADMISSION PROCESS

EFFECTIVE
DATE: 02-02-10

APPROVED BY:

Reviewed (no changes): _____

EXECUTIVE DIRECTOR

POLICY

It is the policy of McIntosh Trail CSB that the admission process for individuals to enter Developmental Disabilities Services starts at the state regional level. It requires that assessments are completed by the regional I&E teams, and services are provided by programs in their local regions.

PROCEDURE

1. All persons requesting institutional or community services in the mental retardation/developmental disability service system do so through the Department of Behavioral Health and Developmental Disabilities (DBHDD) Regional Office. An individual or family member applies for MR/DD services by completing an Application for Developmental Disabilities/Mental Retardation Services. The Regional Office requests the individual or family member to provide copies of any previous psychological evaluations or adaptive behavior testing. The Regional Office will maintain copies of the application and related documentation.
2. The Intake and Evaluation (I&E) Team is responsible for the screening process. Regional Office meets with the individual and/or his or her family member/representative to complete the Intake Screening Tool within 14 business days of the receipt of the application. Information gathered includes background information, functional abilities, developmental milestones, and behavioral and health issues.
3. All supporting documentation is reviewed to determine whether the individual meets the established eligibility criteria. To determine eligibility, the Intake and Evaluation Team members review available copies or prior psychological evaluations and adaptive behavior testing and determine whether additional testing is required. The I&E psychologist reviews and signs off on all determinations. Once an eligibility determination is made, a person receives services at a provider of their choosing or is placed on the region's Planning List. A Planning List Administrator will be assigned to anyone placed on the short-term planning list.
4. For persons recommended by the DBHDD Regional Office for enrollment in NOW/COMP funded services, a comprehensive evaluation is to be completed by the DBHDD Regional Office, including a DMA-6 or DMA-6A form signed and dated by a physician, nurse practitioner, or physician assistant and approved by the DBHDD Regional Office. The DBHDD Regional Office determines whether the individual's needs place him or her at risk of institutionalization in an ICF/MR. The Initial Comprehensive Evaluation, the Individual Service Plan (ISP), and a DMA-6 or DMA-6A form is used to document this determination of eligibility and is reviewed by the Regional Office for level of care determination.

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5. Prior to the comprehensive evaluation process at enrollment in service, an individual is determined by the DBHDD Regional Office to likely require the level of care provided in an ICF/MR through the administration of functional assessment instruments, the review of presenting documentation, and application eligibility standards as defined in Section 701. The participant and his or her legal representative are: (1) provided a brief explanation of the NOW/COMP waiver and informed of alternatives available under the waiver and (2) given the choice of either institutional or home and community-based services. The participant and/or his or her representative must sign the Freedom of Choice Form. In those cases where the beneficiary is unable to comprehend fully the options or consequences of his or her choice, a duly authorized representative of the beneficiary may act on his/her behalf.
 6. Eligibility for services under the waiver may be denied for the following reasons:
 - A. A participant fails to meet the eligibility criteria specified.
 - B. The participant or his/her representative has not supplied information needed to complete the eligibility process.
 - C. The participant or his/her representative has not signed the Freedom of Choice form.
 - D. The Individual Service Plan costs are prohibitive because it increases the average cost of the NOW/COMP beyond the average ICF/MR costs.
 7. A participant denied service or terminated from service because he/her does not meet the level of care requirement is informed of his/her rights to appeal or to a hearing. The DMA authorized representative sends the participant a Denial of Level of Care letter that outlines the procedure to appeal the decision and to request a hearing.