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## **900 PLAN COORDINATION**

### **901 Overview**

This chapter describes how the Division Support Coordinator arranges for and coordinates services, both internal and external to the Division, to meet the needs of eligible individuals as identified in the Individual Support Plan/ Individualized Family Support Plan/Person Centered Plan (Planning Documents). For services funded by the Division, the chapter specifies authorizations including but not limited to prior authorization, requirements for cost effectiveness studies, waiting list procedures, referral and placement procedures, safety consideration for placements including emergency situations, responsibilities for coordinating acute care services with the Long Term Care health plan, requirements for obtaining services out-of-area, and discharge/transfer procedures. It also describes policies and procedures necessary to provide effective, coordinated services with other agencies and programs, such as Department of Child Safety (DCS), Adult Protective Services (APS), Regional Behavioral Health Authority (RBHA), the Arizona Department of Education (ADOE), Arizona Early Intervention Program (AzEIP), Arizona Health Care Cost Containment System (AHCCCS), Health Insurance Portability and Accountability Act (HIPAA), American Indian Health Plan (AIHP) and Children's Rehabilitative Services (CRS).

### **902 Responsibilities of the Plan Coordinator – Residential Placements**

The Division Support Coordinator is typically the plan coordinator. In an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), the Qualified Intellectual Disabilities Professional (QIDP) is the plan coordinator. The responsibility of the plan coordinator is to assist members in accessing services by ensuring that services, activities, and objectives identified in the Planning Documents are arranged for and implemented.

At the time of placement, the Support Coordinator is responsible for the following:

- A. If a member's behaviors pose a danger to residents or staff, the Division will share this information with the parents/ guardians of other residents in the home. The agency director, designee, or Division staff will only provide non-personally identifiable information to the guardian.
- B. For a member currently in placement or using out-of-home respite and potentially at risk, the Support Coordinator along with the Individual Support Plan (ISP) team will identify the appropriate person to inform the family of the risk.

In cases of emergency placement, the checklists capturing potential safety concerns for everyone in the home must be available to the guardian/family of the member moving in.

### **903 Selection of Providers**

The member or the member's representative may select a provider from a list of Qualified Vendors (QVs) or Individual Independent Providers (IPs). The Division will match the member with a provider able to meet the needs identified in that individual's Planning Documents.

While it is unacceptable for the Support Coordinator to select providers for the family/member, the Division is responsible for assisting the family/member with identifying criteria that will help narrow the list of available providers. The criteria are based on the needs and preferences of the family/member. It is acceptable for the Support Coordinator to contact the provider to help determine availability.

The Division has implemented a process and developed procedures for purchasing Home and Community Based Services (HCBS). The procedures apply to the selection of a provider of community developmental disability services. Professional organizations, professional independent providers or IPs who become QVs may be selected. For more information regarding QVs, purchasing services and IPs refer to Arizona Administrative Code (A.A.C.) R6-6-2101 through R6-6-2115 [azsos.gov/public\\_services/Title\\_06/6-06.htm](http://azsos.gov/public_services/Title_06/6-06.htm).

These procedures also apply to HCBS selection when:

- A. A member who is new to the service system is seeking a provider.
- B. There is a change in a provider requested in the Planning Documents at the time of the annual review. This request requires an explanation. The Division shall accommodate the request, to the extent appropriate and practical as determined solely by the Division.
- C. The member or the member's representative requests a change outside an annual review. The member/responsible person must state in writing or must report to the Support Coordinator for incorporation into the Planning Documents the following:
  1. The rationale for changing providers
  2. A description of the opportunities given to the current provider to address the member's concerns
- D. Any changes for members over the age of three must be documented on the *Changes in the ISP*.

- E. For children in the Arizona Early Intervention Program (AzEIP) the chosen provider is documented directly on the Individualized Family Service Plan (IFSP), with the date and the responsible person's signature.

#### Individual Independent Provider Selection Process

The Individual Independent Provider (IP) selection process is designed to be self-directed by the member. Specific procedures shall be followed in the event a member/responsible person identifies or wishes to choose an IP. A fiscal intermediary shall be assigned if an IP is chosen by the member. The Division requires the use of a fiscal agent to manage the tax responsibilities and other employer obligations related to IP selection.

The fiscal intermediary for the member and family shall:

- A. Work with the Division and the Arizona Health Care Cost Containment System (AHCCCS) to develop appropriate informational materials to assist members and their families with choosing an IP.
- B. Work with the Division to successfully transfer funds and any necessary confidential information.
- C. Maintain member and family information in a confidential manner and in compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations (See Records Management in this Policy Manual).
- D. Provide direct easy access to customer representatives who can assist with answering questions and resolving concerns.
- E. Pay claims submitted by IPs, including tax obligations.
- F. Maintain a declining balance for each service for each member that is submitted to the member regularly.
- G. Maintain a system that ensures that the member/family has an available reserve of support hours for each service provided.
- H. Work with members, families and the Division to resolve any financial concerns.

When a family chooses an IP to provide authorized supports as cited in the Planning Documents the member/family shall:

- A. Use a fiscal intermediary to act as their agent for payroll and tax purposes.
- B. Hire, orient, and train each IP to deliver the support as authorized in the Planning Documents.
- C. Review and sign each IP time sheet.
- D. Track the hours of service used against the hours of service authorized.
- E. Report any concerns to the Support Coordinator, and work with the fiscal intermediary and Division staff toward resolution.

The provider for each service shall:

- A. Have a contract with the Division.
- B. Work with the fiscal intermediary chosen by the member/family to complete all requirements.
- C. Work with the fiscal intermediary and the Division to resolve concerns.

Although provider selection is intended to be self-directed by the member, service delivery and provider selection is further determined by:

- A. The planning process initiated by the Planning Documents that identifies the need and timelines for services funded by the Division.
- B. The Planning Team has the option of completing the *ISP/IFSP Individual Attributes Checklist* to assist in the IP match process. This checklist will be filed in the referral section the member's case file.
- C. Services are reviewed and approved per the Division's statewide service approval process. The Support Coordinator initiates the service approval process within five (5) working days from the date of identified need and within the timelines of service need specified in the Planning Document.
- D. The District will maintain a list of IPs for the member/responsible person's consideration. Identification of the Individual Independent Provider is recorded on the Planning Documents.

- E. The District designee completes the *Rate Assessment* with the member/responsible person. The assessment is filed in the referral section of the member's case file.
- F. Once the service is approved, the Support Coordinator or designee documents the member/responsible person's choice of provider and follows the District's authorization process.

#### Qualified Vendor Selection Process

When a member/family identifies or wishes to choose a Qualified Vendor (QV), the following process is implemented:

- A. The planning process identifies the need for services funded by the Division.
- B. The Planning Team may complete the *Individual Attributes Checklist* that is optional for the QV match process.
- C. The member/responsible person indicate whether they will contact the potential providers to assess availability or if the Support Coordinator or designee will assist. The Support Coordinator documents the choice.
- D. Services are reviewed and approved per the Division's statewide service approval process. The Support Coordinator initiates the service approval within five (5) working days from the date of identified need. If services are denied, a *Notice of Action* form must be completed and processed.
- E. The District shall maintain a Qualified Vendor directory that includes objective and factual attributes. This information will be used to assist the member/responsible person in selecting a QV.
- F. Support Coordinators and Division staff are not permitted to recommend any specific provider. If the Support Coordinator or Division staff is asked to make a recommendation regarding a provider, this request cannot be granted. The Support Coordinator must explain to the member/responsible person that the QV directory lists all of the providers who are certified as Qualified Vendors for the service needed. If the Support Coordinator or designee is delegated to confirm availability, he or she must be unbiased in contacting providers.
- G. The member/responsible person identify the chosen Qualified Vendor.

- H. The member/responsible person or Support Coordinator/designee will notify the provider of the service need and the member's attributes. The provider must make contact with the member/responsible person or express interest in delivering services to the member within five (5) working days.
- I. The provider selected by the member/family is documented in the Planning Documents. If the provider is identified outside of the Planning Meeting, this must be recorded on the *Changes in the ISP*.
- J. For Arizona Early Intervention Program (AzEIP) eligible children the chosen provider is recorded directly on the Individualized Family Services Plan (IFSP), with the date and the responsible person's signature.
- K. No change in the Planning Document is required for the fiscal Intermediary when changing providers outside of a planning meeting.
- L. The Support Coordinator/designee verifies or provides contact information to the available provider and member/responsible person to facilitate the introduction of member and provider.

When the member/responsible person notifies the Support Coordinator of an approved provider:

1. The Support Coordinator confirms the provider and member/responsible person match.
2. The Support Coordinator documents the member/responsible person's choice of provider and follows the District's authorization process.

### Vendor Call Process

When a member/responsible person does not express a preference for a specific provider, they may request a Vendor Call for Services to identify potential providers for home and community based services (HCBS). The Vendor Call for Services invites Qualified Vendors (QVs) to submit a response indicating their availability to provide an identified service.

The Division may transmit or post a Vendor Call for Services that includes:

- A. Only non-identifying information about the member or group of members.

- B. A summary of service needs as outlined in the Planning Document.
- C. Any special accommodations that the member(s) requires, including behavioral health, transportation, health care, personal preferences, etc.
- D. Positive attributes and strengths of the member, such as hobbies, favored activities, preferences and likes.
- E. The desired timeframe for delivery of services.
- F. The date when the Vendor Call Response is due.
- G. To whom the response is submitted.

The Qualified Vendor shall submit a written response to the extent requested that outlines:

- A. The experience and background to provide the requested service(s).
- B. A written plan to meet identified needs described in the member's Planning Document.
- C. A description of how any special accommodations will be met.
- D. A timeframe by which the service will be delivered.
- E. Any additional information responsive to the Vendor Call for Services.

The Division designee(s) shall review all Vendor Call Responses received within the requested timeframe. Responses shall be evaluated based on the QV's written response as to how it will meet the member's service needs and accommodations included in the Vendor Call for Services. Within fourteen (14) days of the response due date, the Division shall notify each QV whether or not the submitted response fulfills the need specified in the Vendor Call for Services.

The Division shall provide the member/responsible person with a list of providers that meet the needs of the member. Prior to making a selection, the member/responsible person may request to meet with one or more of the QVs listed. The Division shall provide at least 48 hour notice to the QV when scheduling the meeting.

For all residential and day program services, the Division shall provide the following redacted, non-identifying information to the Qualified Vendor:

- A. The current Planning Document.
- B. Any historical and behavioral information necessary for the provider to anticipate the member's needs.
- C. Summary information from the Program Review Committee.
- D. Serious incidents reviewed by the Human Rights Committee within the past year.
- E. Behavior treatment plans .
- F. Additional information specific to the member and his/her support needs.

If the member/responsible person have signed a Health Insurance Portability and Accountability Act (HIPAA) release, the documentation provided to QVs in response to a Vendor Call does not require redaction. Providers who request to review the entire member file may do so with the written permission of the member/responsible person.

A Qualified Vendor may withdraw its response to a Vendor Call for Services at any time prior to when the member/responsible person or the Division makes a final selection. The final selection will be documented by the District in an authorization transmitted formally to the vendor, noting service codes, rate of reimbursement, level of staffing, target dates, etc. After a final selection has been made, the QV may not refuse to provide the authorized services for the member based on the difficulty of supports needed by the member.

#### Random Auto-Assignment Process

When the member/responsible person is unwilling or unable to choose a provider, the Division's Business Operations Unit will randomly assign a QV.

#### Notification of Network Changes

The Division will notify members/families who receive services of discontinued contracts for personal care providers, attendant care agencies, etc. The Division will send a letter to the member/family fifteen (15) days after receipt of the termination notice by the Division.

### **904 Short Term Emergency Situations (Residential and Day Programs)**

To protect the health and safety of a member, a Qualified Vendor (QV) must notify the Division within twenty-four (24) hours (including weekends) if an

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emergency situation exists in which the provider is unable to meet the health or safety needs of a member.

The QV shall explicitly specify the need for increased staffing due to the emergency. Emergency situations may include but are not limited to: acute psychiatric episodes, suicide attempts, deaths in the immediate family, severe and repeated behavioral outbursts, acute and disabling medical conditions, evacuations, etc.

Notification of all emergency situations shall be made to the District Program Manager (DPM) or designee *and* the Central Office. The notification for increased emergency staffing must be honored if verification is present in any form that reasonably could be considered notification, including notification to after hour on-call, e-mail.

The DPM/designee shall provide written approval/denial of emergency increased staffing to the QV. When approving an extension for emergency increased staffing (maximum is an additional fifteen [15] calendar days), the DPM/designee shall take into account the needs of the member receiving services and the capacity of the provider.

If a provider believes an inpatient placement is appropriate, the local Regional Behavioral Health Authority (RBHA) should be contacted for evaluation/placement.

#### Resolution of Emergency Situations

Upon notification from the QV, the DPM/designee will notify the Support Coordinator of the emergency situation. Within fifteen (15) working days of notification of an emergency situation, the support coordinator shall convene a Planning Team meeting to recommend any changes, including whether there is a need for additional temporary staffing to provide for the health and safety of the member.

If a need for additional temporary staffing is recommended beyond the initial emergency authorization for increased staffing, the Support Coordinator shall notify the DPM/designee of the continued need.

Within thirty (30) working days of initial notification of an emergency situation, the Planning Team, including a Division resource manager/designee, shall develop a written plan to resolve the situation.

The plan for resolution must include:

- A. The change in behavior or condition that precipitated an emergency situation
- B. The actions being taken to assist member (medical or psychiatric appointment, arranging for positive behavioral support, grief counseling, etc.)
- C. The projected date of completion for each step
- D. The criteria that would indicate the additional staffing levels are no longer needed

The support coordinator shall provide the written plan of resolution to the District Program Manager/designee for review and approval.

#### Qualified Vendor Request for Informal Review

After selection by the member/responsible person or the Division, or implementation of a plan to resolve an emergency, the QV discovers that it cannot meet the needs of a member; the vendor may request an informal review by the Division. The QV shall submit this written request for review to the DPM and provide notification to the Central Office.

The DPM shall review the facts and provide the final decision in writing to the QV within 21 calendar days of the request for a review. If the DPM rejects the vendor's request, the DPM shall provide the QV with the reason for the decision.

If the DPM approves the QV's request to discontinue providing services to the member, the QV shall not discontinue service provision until an alternate provider is selected and the member is transitioned to the new provider.

A.A.C. R6-6-2110

[azsos.gov/public\\_services/Title\\_06/6-06.htm](http://azsos.gov/public_services/Title_06/6-06.htm)

### **905 Referral and Placement in Services**

Following completion of all authorization procedures the Support Coordinator shall contact the identified provider and arrange to initiate the service.

Prior to a member starting a service, the Support Coordinator shall send a copy of the Planning Documents to the identified provider.

Preschool-age children shall not be placed in a Child Developmental Foster Home without a stay-at-home parent, unless all other alternatives have been exhausted and the Assistant Director has given approval. There may be exceptions to this requirement for children whose cases have been transferred to the Division from

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Department of Child Safety (DCS). All other alternatives include currently available Child Developmental Foster Homes.

The Division staff shall also make every attempt to develop an appropriate home if one is not available. The Assistant Director will consider the need for expansion of a Child Developmental Foster Home after the family's situation and family dynamics have been thoroughly explored. Child Developmental Foster Home expansion will not occur unless it is determined that the child can fully benefit from this placement, and that the quality of care and supervision of other members who reside in the home will not be adversely affected.

For members being placed in residential or day program service settings, the Support Coordinator shall also send to each provider the following information:

- A. Demographic information that includes the member's name, address, telephone number, date of entry into the Division system, Focus identification number, legal competency status, language spoken and understood, name of parent/responsible person or next of kin (with address and telephone number), physician's name, address and telephone number, and Third Party Liability (TPL) information (company, policy number, etc.). Printouts of the appropriate Focus documents and/or Planning Documents should contain most of this information, and will be acceptable documentation for referral purposes.
- B. Current and appropriate consents and authorizations.
- C. Description of special needs and how these should be met (e.g., medical or behavioral), if not thoroughly documented on the most recent Planning Documents.
- D. A copy of most recent physical examination.
- E. Medical history, including results of Hepatitis B and tuberculosis tests, and immunization records, if available.
- F. Current medications and medication history, if not thoroughly recorded on the most recent Planning Documents.
- G. Copies of other assessments necessary to provide effective services, such as vision and hearing screenings, dental records, therapy evaluations, psychological evaluations.

In the event these records are not available, the Support Coordinator should assist the provider in scheduling appointments or obtaining the records needed to meet minimum residential licensing requirements.

For members being placed in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), a physician's order and the approval of the Assistant Director shall accompany the above information. The Assistant Director may delegate selective authority.

The Planning Team shall schedule a pre-placement meeting with the provider to introduce the member, review the Planning Documents and other records, and discuss any other information necessary to provide safe and effective services. The Support Coordinator shall coordinate and attend pre-placement meetings for residential and day program settings. The Support Coordinator shall determine the need to attend pre-placement meetings for other home and community based services on the circumstances of each case.

#### **906 Service Provider Information, Authority and Notification**

The Division shall disclose to a service provider in the Planning Document, and in all meetings resulting from a response to a Vendor Call for Services, any historical and behavioral information necessary for the provider to anticipate the member's future behaviors and needs. This includes summary information from the Program Review Committee, Unusual Incident Reports reviewed by the Human Rights Committee, and Behavioral Health Treatment Plans. The Division will redact the member's identification from this information.

Service providers are authorized to engage in the following activities in accordance with the member's Planning Document:

- A. Administer medications, including assisting the member's self-administration of medications.
- B. Log, store and dispose of medications.
- C. Maintain medications and protocols for direct care.

The Department may establish procedures for items "A" through "C" listed above.

To protect the health and safety of a member, a provider must notify the Division within 24 hours if an emergency situation exists in which the provider is unable to meet the health or safety needs of the member.

On notification of an emergency, the Department shall hold a Planning Meeting within 15 days after notification to recommend any changes, including whether there is a need for temporary additional staffing to provide appropriate care for a

member, and shall develop a plan within 30 days after notification to resolve the situation.

#### Other Safety Considerations for Placements

Prior to any out-of-home respite or residential placement (including emergencies), the *Pre-Service Provider Information*, *Residential Transfer Checklist*, and any other pertinent forms shall be completed to gather general care information and identify potential safety concerns to prevent risk to the member, other residents, staff and the public.

The Planning Team shall complete the *Case Transfer* form as part of the pre-placement meeting.

The Planning Team will identify in the Planning Document appropriate means to deal with potential safety risks including, but not limited to training, inoculations, and staffing as needed.

The Planning Team, in consultation with law enforcement, Behavioral Health, the Department of Child Safety (DCS), or other members/agencies as appropriate, will identify planned responses to known problems prior to placement, and document them on the *Risk Assessment*.

### **907 Discharge Planning**

Discharge planning is a systematic process for the transition of a member from one health care setting to another or the transition of a medically involved member from one residential placement to another. The key to successful discharge planning is communication between member, family/caregiver and health care team. Depending on the specific needs of the member, the following people may participate in the discharge planning process:

- A. Member/family/caregiver
- B. Primary care provider/specialist
- C. Discharge Coordinator/Social Worker/Quality Assurance Nurse
- D. Utilization Review Nurse (hospital, Division or Health plan)
- E. The Division Discharge Planning Coordinator
- F. The Division Support Coordinator
- G. Other Planning Team members, as necessary

In order to ensure that Support Coordinators and District Nurses are aware of hospitalizations of Arizona Long Term Care System (ALTCS) eligible members, the Medical Services Representative will e-mail the Support Coordinator and District Nurse identified in Focus when notified of an admission. It is the responsibility of the Support Coordinator to notify the Division's District Nurse or Discharge Planning Coordinator of transfers of medically-involved members, or the hospitalization of a non-ALTCS eligible member.

The discharge planning process is applicable in health care settings, and in the transfer of a medically involved member from one Child Developmental Foster Home, Adult Developmental Home, Group Home, and Intermediate Care Facility for Individuals with an Intellectual Disability or Nursing Facility to another. The process will generally include the following activities:

- A. Complete a Division Discharge Plan Assessment, e.g., nursing assessment
- B. Review of discharge orders written by doctor
- C. Ensure that the member/family/caregiver has received proper training to carry out the discharge orders
- D. Ensure that all necessary equipment and supplies have been ordered and will be available when needed
- E. Ensure that transportation arrangements have been made
- F. Reinstate applicable service(s) that may have been interrupted, or initiate services now determined needed (update Planning Documents)
- G. The District Nurse or Discharge Planning Coordinator will complete a *Utilization Review Nursing Worksheet – Health Care Services*, and send copies to the Support Coordinator and Health Care Services (HCS)
- H. Notification and/or signatures as required on the *Utilization Review Nursing Worksheet – Health Care Services* form:
  - 1. Health Care Services Representative (District Nurse and/or Discharge Planning Coordinator)
  - 2. District Program Manager or designee (to be notified about all changes of placement)

3. Medical Director (to be notified by HCS of level of care changes)
4. The Division Assistant Director/designee (signature also required for placement in an ICF/IID)

### Members with Medical Needs

Members are considered to be medically involved when they require two or more hours per day of skilled nursing care. Thorough discharge planning for people who are medically involved ensures continuity of a member's services when the member is moving from one setting to another. Placement and services should be appropriate and established prior to the member being discharged.

The Support Coordinator, District Nurse and/or the Discharge Planning Coordinator will work together to initiate the discharge planning process. Their communication can include a Planning Document. Convening a Planning Team meeting is at the discretion of any member.

The following procedures shall be implemented for all members who are medically involved:

- A. The District Nurse will verify hospitalization notification and/or transfer intentions with the Support Coordinator.
- B. The District Nurse or Discharge Planning Coordinator shall follow the hospitalization and keep the Support Coordinator updated on the member's condition and the concerns expressed by the member/family/caregiver.
- C. A Planning Team meeting should be called prior to discharge for complex cases. The hospital discharge planner is considered the lead in this meeting, and should assemble the family/caregiver, attending physician, primary care provider (if possible), social services, the Support Coordinator and Division Nurse, the health plan utilization review nurse. Other disciplines may be included, particularly if their role influences the member's discharge status/planning (i.e., Department of Child Safety or Adult Protective Services).
- D. If placement is an issue:
  1. A nursing assessment will be updated/completed, to assess the nursing/medical needs of the member and identify the appropriate type of facility/residence.

2. If behavioral health is a need, referral to the Regional Behavioral Health Authority (RBHA) should be made by the Support Coordinator to initiate assessment and their participation in the discharge planning process.
  3. Based on the Planning Documents, the Support Coordinator will then work with the appropriate staff to arrange for the facility/residence which will provide for the identified needs.
- E. If the Division is expected to pay for an ICF/IID placement, a thorough review is required, including Health Care Services, before any admission is made. All placements in ICF/IID(s) must have the approval of the Assistant Director. These facilities are restrictive environments, therefore, placement is temporary and transitional, occurring only after the following alternative options have been eliminated:
1. In-home supports.
  2. Individually Designed Living Arrangement.
  3. Community based placements, i.e., Group Home, Child Developmental Foster Home (CDH) or Adult Developmental Home (ADH).

See Policy Manual for more information on ICF/IID.

- A. For those members who are returning to an ICF/IID, the District Nurse or Discharge Planning Coordinator shall participate in the planning process. The entire planning process shall be completed before the discharge/transfer is made.
- B. In the absence of a Planning Meeting, the District Nurse and/or Discharge Planning Coordinator will coordinate the discharge orders, caregiver training, equipment/supplies, home health care and transportation.
- C. The Division Nurse or Discharge Planning Coordinator shall complete a *Utilization Review Nursing Worksheet – Health Care Services* upon discharge, and send copies to the Support Coordinator and HCS.
- D. The Discharge Plan shall take precedence over any Planning Document objectives that are in conflict. If there is a conflict, a new Planning Document shall be developed as soon as possible. The member/responsible person, primary care provider or any other

attending physician involved shall resolve disagreements. The medical records and a summary of the disagreement may be sent to the Discharge Planning Coordinator to be reviewed. The Division's Medical Director may be contacted to review the case and assist in the resolution of the disagreement.

- E. The member's primary care provider shall be given the opportunity to participate in the discharge planning and review the completed Planning Document.

#### Nurse Consultation to Determine Medical Needs

The District Nurse or Discharge Planning Coordinator may be contacted directly by the Support Coordinator to review a member's hospitalization or transfer plans to determine if medical discharge planning is needed. A *Utilization Review Nursing Worksheet - Health Care Services* should be completed by the District Nurse or Discharge Planning Coordinator and submitted with appropriate documentation to HCS and the Support Coordinator indicating if skilled nursing needs have been identified.

#### Members Without Medical Needs

For non-medically involved members who are being discharged from a hospital or skilled nursing facility, the following procedures shall be implemented:

- A. The Support Coordinator shall assess for medical needs prior to discharge. If needed the District Nurse or Discharge Planning Coordinator will complete a *Nursing Assessment - Health Care Services* to plan and recommend an appropriate level of care.
- B. If the member is non-medically involved, the Support Coordinator will:
  - 1. Ensure that training of caregivers has taken place.
  - 2. Assess for and authorize in-home supports as appropriate.
  - 3. Make arrangements for equipment, supplies, medications, etc. through appropriate systems.
  - 4. Ensure that follow-up instructions are in place.
- C. In those situations where a residential setting will change, the Planning Document process shall be an essential part of discharge planning.

### Foster Care Discharge Planning

For all members in foster care, the following discharge planning procedures shall be implemented:

- A. The Support Coordinator, District Nurse or Discharge Planning Coordinator will assess for medical needs prior to hospital discharge. If medical needs are present, the nurse will complete a *Utilization Review Nursing Worksheet – Health Care Services*, and coordinate a plan of care, training for caregivers, and equipment and supply needs. A *Nursing Assessment - Health Care Services* will be updated/completed to determine home based nursing services and/or placement needs.
- B. The District Nurse or Discharge Planning Coordinator must be notified:
  - 1. Prior to any foster child being admitted to or discharged from an ICF/IID or Nursing Facility (NF).
  - 2. Prior to any foster child that is medically involved and/or receiving home based nursing services or being considered for a change in placement.
- C. The Planning Team must be notified prior to this change of placement. The District Nurse or Discharge Planning Coordinator will complete the *Utilization Review Nursing Worksheet – Health Care Services*, and coordinate plan of care, training, and equipment and supply needs. The District Nurse or Discharge Planning Coordinator will notify HCS of changes in placement. The Support Coordinator will notify the District. Specific to an ICF/IID admission, the personal authorization of the Assistant Director (or designee) is required.
- D. Children in foster care whose cases have been transferred from DCS to the Division may also require the participation of court appointed special advocates, attorneys, guardian ad litem or other professionals from the juvenile court.

### Discharge/Transition of Members with Severe Behavioral Challenges

When a member with severe behavioral health challenges is placed into a psychiatric hospital setting, the Support Coordinator will begin discharge planning immediately and District Personnel will attend a hospital staffing within seventy-

two (72) hours. Support Coordinators should, if possible, attend all subsequent hospital staffings. Prior to discharge, the Support Coordinator will:

- A. Involve staff responsible for contracting with Provider Agencies as soon as possible;
- B. Begin the appropriate Planning Process; and
- C. Ensure that staff from the behavioral health system is invited to all planning sessions.

Use of the *Discharge/Transition Checklist for Individuals with High Risk Behavioral Challenges* is mandated when planning discharge from an inpatient setting for members with severe behavioral challenges. The form can also be used when someone with behavioral challenges moves from one setting to another. The form is intended to provide reminders to the team about important areas to consider and should be used to plan for the discharge/move.

The *Emergency Contact Plan* is intended to record very basic information about the person that would be helpful to others coming in to assist in a crisis situation, such as crisis mobile team members or police officers. The form should be completed at the discharge/transition-planning meeting and updated as necessary. The representative from the behavioral health system should assist in filling out the form and the same information should, if possible, be on file with the RBHA. The *Emergency Contact Plan* should be kept in an easily accessible place in the setting, but it should never be posted.

The *Emergency Contact Plan* does not take the place of the Behavior Treatment Plan. Begin development of the behavior treatment plan prior to discharge, so that the person is discharged with at least a rough draft of the plan that eventually gets submitted to the Program Review Committee. This initial plan may be called a "crisis plan." It should have information about precursors/antecedents and creative strategies for preventing challenging behaviors. It should give staff ideas for teaching replacement behaviors, and it should let staff know whom to call when a crisis occurs.

## **908 Residential Placements for Educational Reasons (A.R.S. § 15-765)**

A.R.S. §15-765 allows for residential placements for children for educational reasons. It is not intended to provide long term or permanent residential placements for children. These placements should be for a limited period of time and only for the purpose of accomplishing specific educational goals that promote the child's ability to benefit from a special education program in a less restrictive

environment. A.R.S. §15-765 [www.azleg.state.az.us/arizonarevisedstatutes.asp](http://www.azleg.state.az.us/arizonarevisedstatutes.asp) requires that residential placement be made for educational reasons only and not for other issues, such as family matters.

In the event the child may need some level of intervention beyond what is available through the Local Education Agency, a representative from the school should collaborate with the family or legal guardian to identify resources available to the child, This may include services covered by either private insurance or the Arizona Health Care Cost Containment System (AHCCCS) behavioral health benefits. If the child is currently not enrolled in AHCCCS but may be eligible through Title XIX/XXI (KidsCare), the Public Education Agency should assist the family in the enrollment process.

When an out-of-home placement is considered, priority should be given to placement in the home school district so the child can either maintain placement or transition into the district when specific behavioral or educational goals have been met. Exceptions may exist for children with unusually complex educational needs that cannot be met in the home district, for example, in remote areas of the State. However, these reasons must be clearly documented before the placement is approved.

When the Individual Education Program indicates that out-of-home placement for educational purposes may be necessary, the Support Coordinator shall immediately notify the Division District Program Manager (DPM) for involvement in the placement process. If placement is to be made out of the Division District where the child resides, the Support Coordinator/originating District Program Manager (DPM) must contact the District Program Manager (DPM) in the receiving District in order to facilitate appropriate placement and services.

When requesting residential services for educational reasons through the Division, the following documentation must be provided by the requesting school district to the Support Coordinator. Copies of this documentation shall be placed in the case file. This information is then forwarded to the DPM and Central Office.

- A. A letter of request for services.
- B. Parental signature for consent for evaluation and services.
- C. A copy of the Individual Education Program (IEP) that includes:
  1. Documentation of least restrictive environment considerations, including the specific reasons why the child cannot be educated in a less restrictive environment.
  2. Specific services requested, such as residential placement.

3. Length of time for the placement. For example, six months, one school year.
  4. The exit criteria (goals which when accomplished will indicate that the child is ready to return home or to the home school district).
- D. If the member is being placed outside the state and is eligible for the Arizona Long Term Care System (ALTCS), the Arizona Health Care Cost Containment (AHCCCS must approve the placement in advance.

Incomplete documentation of the educational reasons for requesting residential placement will result in a delay. The Division Central Office may also deny the request.

Following approval and placement in an out-of-home setting for educational purposes, the need for placement shall be reviewed every 30 days after placement by the respective planning processes (Individual Education Program/Individualized Family Services Plan/Person Centered Plan meetings). The results of the review shall be documented in the progress notes. Requests for continuation of the placement must be submitted to the Division Central Office for approval by June 15 of each year. Requests for continued placement shall contain the same information and be submitted in the same manner as required for initial placements.

During the 30-day reviews, all parties shall consider progress according to the goals and objectives of the treatment plan and the Individual Educational Program (IEP) exit criteria. Each review shall also include a discussion surrounding the type of educational and behavioral health supports that would be needed to return the child to a less restrictive placement.

Anticipated transitional supports shall be discussed during the 30-day reviews. The Local Education Agency and the Regional Behavioral Health Authority (RHBA) shall both strive to ensure that the necessary educational and Title XIX/XXI behavioral health supports shall be available to the child and family at time of discharge.

Any proposed change in a residential placement for educational reasons must be made through the IEP review process. Changes in placement must be consistent with the goals of the child's IEP and recommended by the team. Placements may not be changed for reasons other than those related to educational purposes.

When a child's parents move to a new school district, the District that placed the child must notify the new school District of the placement arrangements.

The new District has the responsibility to review the appropriateness of the placement and use the IEP process to make any recommended changes.

When a child is promoted to a high school district, the District that placed the child must treat the promotion as a change of placement and must include the high school District in the IEP review process.

When the team determines that a child needs Extended School Year Services, no change in the residential placement may be made unless specified in the Individual Education Program (IEP).

<http://www.azleg.state.az.us/arizonarevisedstatutes.asp>

#### Transition to the Community

- A. When the child's treatment goals and the IEP exit criteria have been met, the Division, Local Education Agency, Regional Behavioral Health Authority (RBHA), family or legal guardian and residential provider shall collaborate on the necessary planning for transition to a less restrictive setting. At that time, the IEP shall be revised and the treatment plan updated.
- B. The Division, Local Education Agency, RBHA and family or legal guardian shall coordinate with the residential facility provider to schedule a discharge date.
- C. The Division, Local Education Agency and the RBHA shall ensure the agreed upon educational and Title XIX/XXI behavioral health supports are in place for the child and family upon discharge.

Post-discharge, the Division, the Local Education Agency and the RBHA shall continue to monitor the child's status in the less restrictive placement. Communication between the Division, the Local Educational Agency and the RBHA shall continue in order to monitor and support the child's successful integration in the new setting.

#### Preschool Transition

The Division has entered into an Intergovernmental Agreement (IGA) with the Arizona Department of Education (ADOE). The purpose of this agreement is to ensure that children reaching their third birthday complete the transition from services provided by the Division's early intervention programs to an appropriate public education with minimum disruption and stress on the child and family.

#### Oversight Responsibility

The Division partners with the AzEIP (Arizona Early Intervention Program) service provider agencies and the early intervention service providers.

The Arizona Department of Education (ADOE) oversees compliance with Part B of the Individuals with Disabilities Education Act of all public education agencies.

### Agency Responsibilities

#### Notification by the Arizona Early Intervention Program (AzEIP)

The Support Coordinator is responsible for notifying the Local Education Agency and the Division by February 1 of each school year, of children who will be transitioning in the upcoming 16-month period (February through May of the following year), by preparing a list of children which will contain only directory information consistent with the Family Educational Rights and Privacy Act regulations found at 34 Code of Federal Regulations §§99.31 and 99.37 (<http://www.whitehouse.gov/OMB/>). Directory information consists of the child's name, address, telephone number and date of birth.

On September 15 of each school year, the Support Coordinator will give an updated list of children transitioning between September and May of the school year. The directory information may be shared between the AzEIP and the Local Education Agency without parental consent. This exchange of directory information is allowed in order to comply with the Federal Child Find requirements. All other family and child information may only be shared with parental consent.

For each child receiving Division early intervention services, the Support Coordinator is responsible for requesting written parental/guardian consent to release information.

### Individual Education Program (IEP) Conference/Individualized Family Services (IFSP) Conference

The Individual Education Program conference is a meeting to be held no later than the age 2.6 to age 3 to determine appropriate programming. The Individual Education Program conference can be held at the same time as the preschool eligibility and multidisciplinary conferences. The Individual Education Program conference can also be held in conjunction with the individualized family services plan conference. The required participants for the Individual Education Program conference are the same as the required participants for the preschool eligibility conference/multidisciplinary evaluation team conference.

### Local Education Agency Responsibilities

If the child is eligible for special education, the local education agency shall:

- A. Conduct the combined IEP /IFSP conference.
- B. Obtain parental/guardian consent and offer services to the child.

#### Residential Placement for Other than Educational Purposes

Upon request and approval, people with developmental disabilities under the age of 18 may need out-of-home residential placement in a Division contracted setting.

These reasons relate directly to the child's disability and the genuine inability of the parents to meet the child's needs in the family home, even with the provision of available supports by the Division.

Pursuant to A.R.S. §36-552(C); §36-558(A) and §36-560(B), [www.azleg.state.az.us/arizonarevisedstatutes.asp](http://www.azleg.state.az.us/arizonarevisedstatutes.asp) the provision of State funded services is subject to available appropriations. This necessitates formal consideration and strict budget control by the Assistant Director of all requests for voluntary out-of-home placement for children under the age of 18. Foster Care funds may not be used for voluntary out-of-home placements.

The Assistant Director will decide whether or not a voluntary out-of-home placement is in the best interest of the child based on the circumstance of the case. This decision is contingent upon available funding. This decision is also based on the following criteria:

- A. After specified procedures, the parents and other members of a school district Individual Education Program (IEP) team, in consultation with the Division, have determined that the child requires a time limited out-of-home placement in order to receive an appropriate special education (A.R.S. § 15-765). [www.azleg.state.az.us/arizonarevisedstatutes.asp](http://www.azleg.state.az.us/arizonarevisedstatutes.asp)
- B. The child is eligible for and receiving Title XIX behavioral health services and a multidisciplinary team, in consultation with the Division, and with the approval of the parents, has determined that the child requires a Department of Health Services (DHS) contracted setting, e.g., a residential treatment center or a therapeutic group home, as a result of behavioral health problems.
- C. The parents and the Individualized Family Services Plan/Person Centered Plan/Child and Family Team Plan determine the child needs

short or long term out-of-home placement after (1), (2) and (3) have been tried or ruled out and if (4) is true (see below):

1. Reasonable efforts by the Division have been made to provide in-home supports and there is documentation that the parents have actively participated and that the supports have not been successful in meeting the child's needs.
2. Parents have explored the option of placement with a relative, with the provision of available supports from the Division and it has been ruled out as a viable option.
3. Alternatives such as part time out-of-home placements have been created and tried without success.
4. Services needed by the child cannot be provided in the home or the community.

Based upon recommendations from the Individualized Family Services Plan/Person Centered Plan, verification that the above criteria have been met or have been determined to be inappropriate and certification as to availability of funds, the District Program Manager (DPM) may recommend the placement to the Assistant Director who must approve the placement.

Responsibilities of the Parents/Guardians:

- A. Parents/guardians must be in agreement with out-of-home placement.
- B. Parents shall visit and approve the proposed placement prior to a decision being made.
- C. Parents shall sign an agreement to contribute financially to the placement. The amount of parental contribution will be determined on a sliding fee scale based on income. If the child receives Supplemental Security Income (SSI), the contribution to the residential costs will equal 70% of the monthly benefit, in addition to the parental assessment. In such cases, the monthly SSI benefit will not be included in the family income when determining the amount of parental assessment.

In addition, parents will provide those items, such as clothing and other personal expenses, which typically are not included in the rate paid to providers of residential services.

- D. Parents shall visit the child and/or take the child home for visits on a regularly scheduled basis. The frequency of the planned visits shall be determined by the parents and the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and will be documented.
- E. Parents will continue to actively participate in the medical care of the child and in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan and Individual Education Program processes.
- F. Parents may request a gradual transition into the placement.
- G. Parents whose cases have been transferred from Department of Child Safety (DCS) have different responsibilities as determined by child welfare laws and the court.

Responsibilities of the Division:

- A. Prior to a placement being made, the Division shall create agreements with the provider for the parents and siblings to visit on a regularly scheduled, frequent basis as determined by the Planning Documents.
- B. Children should be raised within families. Consequently, the Division shall make reasonable efforts to place the child in a setting appropriate for the child that is as homelike as possible and in as close proximity to the family as feasible. This home must be prior approved by the family.
- C. Upon parent request, the Division will plan for and arrange, in coordination with the Planning Team (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan Team), a gradual transition into the out-of-home placement.
- D. The Division Support Coordinator shall visit and assess the appropriateness of the out-of-home placement prior to the child being placed.
- E. The Division Support Coordinator shall visit the child in the residential placement within 10 days of placement and at least quarterly thereafter. This is the minimum visitation frequency, even if Arizona Long Term Care System (ALTCS) guidelines allow for less frequent service plan reviews.

- F. The need for continued out-of-home placement will be reviewed and documented during the ALTCS service plan reviews and semi-annually at the time of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan review.
- G. Since the ultimate goal is for the child to return to the family when possible, the District Program Manager (DPM) shall review and report to the Assistant Director the status of each child in out-of-home placement at least every six months. The review shall ensure that the child's needs are being met in the placement, that the need for placement still exists, that circumstances still meet the placement criteria, that both the Division and the parents have met their responsibilities and that the child has not been abandoned as defined in A.R.S. § 8-546.

<http://www.azleg.state.az.us/arizonarevisedstatutes.asp>

- H. The Division, in coordination with the Planning Team, will facilitate the child's return home as circumstances permit.

In the event an appropriate placement cannot be made within the boundaries of the child's current school district, the Division Support Coordinator should consider the ability of the receiving school district to meet the child's educational needs when planning for the residential placement. In such instances, the Support Coordinator shall immediately contact the Special Education Director of the school district in which placement is being considered. As soon as possible, the Support Coordinator shall provide the following information to the Special Education Director:

- A. The target date the child will establish or change residence.
- B. A copy of court order(s) establishing dependency, legal guardianship or surrogate parent, if appropriate.
- C. All relevant psychological, educational and medical records including the most recent psychoeducational report; relevant social and developmental history, immunization record, medical certification within the last three years of a physical disability, visual impairment or hearing impairment. Current educational records including the Individual Education Program (IEP), placement statement and therapy reports/evaluations if a psychoeducational report does not exist, the school district is responsible for completing the evaluation.

Within 5 days of receipt of this information, the Special Education Director should contact the Division Support Coordinator to set a date for a multidisciplinary

conference and initiate the evaluation and Individual Education Program (IEP) processes for special education placement. If a parent, legal guardian or legally appointed surrogate parent is not available to consent to evaluation and special education placement, the Division Support Coordinator shall work cooperatively with the local education agency's Special Education Director to obtain appointment of a surrogate parent.

The Division Support Coordinator shall participate in IEP meetings for children in residential placements operated by or financially supported by the Division, but may not legally consent to special education placement.