

Appendix A: Self-Direction

Money Follows the Person (MFP) Rebalancing Demonstration

Operational Protocol

Appendix A: Self-Direction

I. Participant Centered Service Plan Development

- a. **Responsibility for Service Plan Development.** Specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O.)
<input checked="" type="checkbox"/>	Case Manager. <i>Specify qualifications:</i>
	DDS hired and qualified State employee Case Manager DSS contract staff hired and qualified as care planner under DSS contract
<input checked="" type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
	DSS hired and qualified State employee Social Worker DMHAS hired and qualified State employee Social Worker
	Other (<i>specify the individuals and their qualifications</i>):

- b. **Service Plan Development Safeguards.** *Select one:*

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

All case managers, social workers, and/or independent brokers support the waiver participant and other team members to develop and implement a plan that addresses the individual's needs and preferences. The case managers, social workers, and/or independent brokers support the individual to be actively involved in the planning process and assist the individual

(if necessary) to identify members of his or her planning and support team and to invite them to the meeting. The case managers, social workers, and/or independent brokers support the individual to determine the content of the meeting and decide how the meeting will be run and organized. Individuals who are interested in self-directing their supports are made aware of the opportunity to hire an independent support broker to assist with planning. If selected, the independent support broker would become a member of the person's planning and support team. The case managers, social workers, and/or independent brokers encourage the individual and family to review assessments and reports before the meeting. The case manager/social worker is responsible to ensure the individual planning meeting is scheduled at a time when the person, his or her family and other team members can attend. The case manager/social worker ensures the individual has a choice of supports, service options, and providers and that the plan represents the individual's preferences. During the planning meeting the individual and team discuss ways to enhance the individual's future participation in the planning process if needed.

- d. Service Plan Development Process** In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A) The applicant/participant, the case manager/social worker, and individuals chosen by the applicant/participant develop the Individual Plan (IP). A re-evaluation is conducted at least annually and at that time an IP is developed for the next year. The participant/applicant can request changes in the plan at any time during the year. The case manager/social worker discusses the requested IP changes with the participant/participant representative and approves or denies the changes.

B) There are 2 assessment tools used for all participants. There is a self-assessment tool used to assist the participant in identifying their own needs. This is considered during the assessment process. Also, there is an assessment tool used to by the social worker/case manager to assess level of care. These 2 assessments vary depending upon the operating unit however all operating units include both a 'professional level of care assessment' and a 'participant level of care self assessment'.

C) The case manager/social worker must educate the applicant/participant and representative about all waiver and Medicaid State Plan services as part of the IP development.

D) The IP must reflect the goals desired by the applicant/participant. The applicant/participant or representative must sign the plan to indicate understanding of the OP. If the applicant/participant does not agree with the OP, the applicant/participant or representative may file an appeal.

E) All MFP demonstration services are considered supplemental to the qualified range of services. MFP demonstration services will enhance the range of services available to the participant but will not duplicate or supplant.

F) The IP shall include the services including units, frequency, scope etc, and the roles of the

applicant/participant, case manager, providers, family and informal caregivers in achieving the goals and meeting the applicant/participant's needs, including health care needs. The case manager/social worker/or care planner is responsible for the quality control function of quality management. This function includes monitoring and overseeing the implementation of the IP. Monitoring and implementing the IP requires that the case manager/ social worker maintain contact with the participant and their representative to ensure appropriate service delivery. Contact occurs at least quarterly. MFP quality assurance staff also reviews cases according to the quality management plan to assure that quality controls in place.

G) The IP can be updated at the request of the participant/applicant, the representative or the provider when the participant's condition or needs change.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Each waiver participant has a Level of Need Assessment and Risk Screening Tool completed regarding his/her skills and circumstances, and reviewed with the Team at least on an annual basis. This tool produces a Summary report that identifies all responses that may present a risk to the participant in medical, health, safety, behavioral and natural support areas. The team is required to address how each potential risk is mitigated in the IP. Included in this response is the use of an emergency back up plan if the participant is reliant upon a paid or unpaid service to provide for basic health and welfare supports.

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

All waiver participants are provided with a complete listing of all waiver service providers at the time of the IP and provider selection process by the case manager/social worker. This list of providers is also available on the ctdssmap.com website. DDS case managers will accompany potential and current waiver participants to different service provider locations if desired to assist in the selection process.

- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

DDS authorizes the IP under the Memorandum of Understanding agreement subject to quarterly retrospective reviews of a sample of 10-15 IPs each quarter by DSS. DDS also prepares quarterly reports of IP quality reviews by DDS case management supervisors, the DDS Medicaid Operations Unit and DDS Quality Service Review results for review and comment by the DSS oversight unit.

While assessments and care plans may be developed by other operating units or contractors depending upon the target population, the care plan must be approved directly by the Medicaid agency before it is funded.

- h. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for the duration of time that the State is operating the MFP project plus one year. For example, if the State enrolls individuals into the MFP program for three years the State

must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following (*check each that applies*):

<input checked="" type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
	Other (<i>specify</i>):

II. Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare – Quality Control (QC); (b) the monitoring and follow-up method(s) that are used; and (c) the frequency with which monitoring is performed.

Target Population	Monitoring Responsibility	Method	Frequency
Aging/Physical	DSS Contractor: Care Planner	Compare IP, vendor quarterly reports; Reviews progress on the plan during reviews at each service site; review of the V/FEA monthly and quarterly expenditure reports for individuals who choose participant-direction; Quarterly contact through the care planner/social worker/case manager	Quarterly or more frequent as needed; In person, at least annually.
Mental Illness	DMHAS Social Worker	Same as above	Same as above
Intellectual Disability	DDS Case Manger	Same as above	Same as above
Acquired Brain Injury	DSS Social Workers	Same as above	Same as above
Dual Diagnosis	One of the above. Dependent upon operating unit responsible for package of services.		

b. Monitoring Safeguards. *Select one:*

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>

III. Overview of Self-Direction

a. Description of Self-Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration’s approach to participant direction.

<p>A) Opportunities for Participant Direction</p> <p>Demonstration participants may choose to self-direct some or all of their services to the extent that the self-direction will be allowed under the 1915(c) waiver in which the participant will eventually be enrolled. See demonstration section B.7 for a description. It is not the intent of the demonstration to allow self-direction under the demonstration for an individual who will not be allowed to self-direct in the waiver in which he/she will eventually be enrolled. To the extent allowed under the 1915(c) waiver, demonstration waiver participants will assume and retain responsibility to:</p> <ul style="list-style-type: none">• Recruit their attendants• Conduct criminal history checks;• Determine the competency of attendant; and• Hire, train, manage, and fire their attendants. <p>The participant/employer may appoint a designated representative to assist with or perform employer responsibilities to the extent approved by the participant/employer. In addition, the participant/employer has a budget authority over the services he or she is directing. In addition to personal attendants, participants are supported in self-directing all or any portion of their services if they so choose. The traditional agency option is available to provide authorized services to participants who decide not to self-direct based on their IP.</p> <p>B) How Participants take Advantage of these Opportunities</p> <p>The case manager/social worker informs the participant of the option to self-direct /select waiver services/demonstration services at the time of enrollment and at least annually</p>
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thereafter. At any time, a participant may elect to self-direct services or to terminate self-direction of services. If the participant/employer decides to terminate self-direction, the case manager/social worker/care planner will ensure that those program services delivered through the self-direction option are transitioned over to services offered through the traditional service delivery model.

C) Entities Supporting Participants who choose to self-direct

- The services of a Vendor Fiscal Employer Agent (VFEA) are required for individuals who self-direct their services and supports. The VFEA assists the individual and/or family or personal representative to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of employment of service workers by the individual or family, including federal, state and local tax withholding/payments, processing payroll or making payments for goods and services and unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, support to enter into provider agreements on behalf of the Medicaid agency, and providing information and training materials to assist in employment and training of workers. This service is required to be utilized by individuals and families who choose to hire their own staff and self-direct some or all of the waiver services in their IP. The service will be delivered as an administrative cost and is not included in individual budgets.

- Independent Brokers are an optional support available to persons served under the DDS and Chronic Care Waiver. Supports include:
 - ✓ Assistance with developing a natural community support network
 - ✓ Assistance with managing the Individual Budget
- Support with and training on how to hire, manage and train staff
 - ✓ Accessing community activities and services, including helping the individual and family with day-to-day coordination of needed services.
 - ✓ Developing an emergency back up plan
 - ✓ Self advocacy training and support

- Case managers, care planners and social workers have various roles supporting self-direction in different HCBS programs. At minimum, their role includes assessment and quality control of services regardless of service delivery model. In some HCBS programs such as those administered by DMHAS and DDS, the role is expanded to essentially also help with roles similar to the independent broker.

D) There is no other relevant information.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the demonstration. *Select one:*

	Participant – Employer Authority. As specified in each 1915(c) waiver’s Appendix E-2, Item a, the participant (or the participant’s representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
	Participant – Budget Authority. As specified in 1915(c) waiver’s Appendix E-2, Item b, the participant (or the participant’s representative) has decision-making

	authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
■	Both Authorities. The demonstration provides for both participant direction opportunities as specified in 1915(c) waiver's Appendix E-2. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** Check each that applies:

■	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
■	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
■	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (select one):

■	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services as specified in demonstration Section B.7. Alternate service delivery methods are available for participants who decide not to direct their services.
	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

	The case manager/social worker provide information about options to self-direct to the participants and their families at the time of the IP meeting and at any time the individual expresses an interest in self-direction. (For persons served by DDS, this includes a Family Manual on Self-Direction and Your Hiring Choices http://www.dmr.state.ct.us/HCBS/DMRbook2ENG.pdf , and informational fact sheets).
	The VFEA (fiscal intermediary) has responsibility to provide fact sheets to individuals who are referred to them who choose to self-direct. Fact sheets include information about criminal background checks, abuse/neglect registry checks, employer responsibilities, hiring and managing your own supports, employee safety: workers compensation and liability insurance. The VFEA ensures that individual provider qualifications and training requirements are met

prior to employment and the appropriate forms to document that training are completed.

f. Participant Direction by a Representative. Specify the State’s policy concerning the direction of demonstration services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of demonstration services by a representative.
<input checked="" type="checkbox"/>	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: (<i>check each that applies</i>):
<input checked="" type="checkbox"/>	Demonstration services may be directed by a legal representative of the participant.
<input checked="" type="checkbox"/>	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant: The State’s practice is to allow participants the opportunity to self direct waiver services with the assistance they need by allowing family members, advocates, or a representative of the participant’s choosing, to assist with the responsibilities of self-direction. A representative does not have to be a legal representative. The representative assumes responsibilities for the Agreement For Self Directed Supports, which is reviewed with the representative and the participant, and signs the Agreement. The participant can also be the sponsoring person. The Agreement for Self Directed Supports includes the identification of areas of responsibility where the responsible person will require assistance. Any assistance needed as indicated in the agreement must be addressed in the participant’s IP. For persons served under the ABI waiver, demonstration services may not be directed by a non-legal representative.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each demonstration service. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
One Time Transitional Fund	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assistive Technology	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Accessibility Modifications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Transition Coordination	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one*:

<input type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

- i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. *Select one:*

<input type="radio"/>	FMS are covered as a Demonstration service	Fill out i. through iv. below:
<input checked="" type="radio"/>	FMS are provided as an administrative activity. Fill out i. through iv. below:	
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: VFEAs are procured through a competitive RFP process. Private not-for-profit and for-profit corporations and LLCs furnish these services. CT DDS pays the VFEAs directly per the contract. Participants who self direct must use a VFEA under contract with the State. CT requires the re-bidding of VFEA contracts every three years. Vendors who were recently awarded contracts as a result of the competitive procurement process, will have contract scopes expanded to provide services under DSS MFP.	
ii.	Payment for FMS. Specify how FMS entities are compensated for the activities that they perform: FMS entities are compensated as an administrative expense based on the number of persons served as detailed in the competitive bidding process.	
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i> <i>Supports furnished when the participant is the employer of direct support workers:</i>	
<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status	
<input checked="" type="checkbox"/>	Collect and process timesheets of support workers	
<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance	
<input checked="" type="checkbox"/>	Other <i>(specify):</i> Verify training requirements of direct support workers are completed.	
	<i>Supports furnished when the participant exercises budget authority:</i>	
<input checked="" type="checkbox"/>	Maintain a separate account for each participant's self-directed budget	
<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds	

<input type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
<input type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the self-directed budget
<input type="checkbox"/>	Other services and supports (<i>specify</i>):
<i>Additional functions/activities:</i>	
<input type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
<input type="checkbox"/>	Other (<i>specify</i>):
iv.	<p>Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.</p> <p>The State conducts an annual performance review of VFEAs. VFEAs are responsible for providing the State with an independent annual audit of its organization and the State funds and expenditures under the agent's control according to procedures dictated by the operating agency's auditing team. In addition, quarterly statements of expenditures against individual budgets are sent to the individual, the regional office in the case of DDS and to the central offices of other operating agencies. These statements are reviewed on a periodic basis as detailed in the quality management plan. In addition to the quarterly statements, an annual expenditure report is submitted for each participant that is reviewed by the State and either accepted or sent back for clarification or changes</p>

- j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:</i></p> <p>Participants served by DDS: The role of the DDS case manager (TCM) in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs and preferences. Case managers support individuals to be actively involved in the planning process. Case managers share information about choice of qualified providers and self-directed options at the time of the planning meeting and upon request. Case managers assist the person to develop an individual budget and assist with arranging supports and services as described in the plan. They also assist the individual to monitor services and make changes as needed. Case managers share information regarding the ability to change providers when individuals are dissatisfied with performance.</p>
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	<p>Individuals who self direct by hiring their own staff will have case manager <u>or</u> a specialized case manager, called a DDS support broker, to assist them to direct their plan of individual support. In addition to TCM activities, the DDS support brokers assist individuals to hire, train and manage the support staff, negotiate provider rates, develop and manage the individual budget, develop emergency back up plans, and provide support and training to access and develop self-advocacy skills. These additional duties are considered outside the scope of the TCM service so the time/costs are not included in the rate setting methodology for TCM.</p> <p>Another option for those who self-direct is to have a TCM <u>and</u> independent support brokerage through the option of FICS under the waiver. This waiver service noted below provides support and consultation to individuals and/or their families to assist them in directing their own plan of individual support. This service may be self-directed or provided by a qualified agency and is available to those who direct their own supports and hire their own staff. The services included are :</p> <ul style="list-style-type: none"> • Assistance with developing a natural community support network • Assistance with managing the individual budget • Support with and training on how to hire, manage and train staff • Assistance with negotiating rates and reimbursements. • Collaborates with TCM and either participates in participant’s planning meetings or is made aware of the participant’s individual plan and goals from both the participant and case manager. • Accessing community activities and services, including helping the individual and family with day-to-day coordination of needed services. • Developing an emergency back-up plan • Self advocacy training and support <p>Participants served by DMHAS: Participants served by DMHAS will use a similar process however there is no option for support brokers.</p>	
<input checked="" type="checkbox"/>	<p>Demonstration Service Coverage. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled:</p> <table border="1" data-bbox="824 1230 1567 1297"> <tr> <td data-bbox="824 1230 1567 1297"> <p>For all others, case management demonstration service, independent broker</p> </td> </tr> </table>	<p>For all others, case management demonstration service, independent broker</p>
<p>For all others, case management demonstration service, independent broker</p>		
<input type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i></p>	

k. Independent Advocacy (select one).

<input checked="" type="checkbox"/>	<p>Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p> <p>Independent advocacy is available to participants through the Office of the Ombudsperson for Developmental Services as well as through the use of an FICS (independent support broker), Office of the Ombudsman, AAAs, CILs, and Office of Protection and Advocacy.</p>
<input type="checkbox"/>	<p>No. Arrangements have not been made for independent advocacy.</p>

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Individuals may through the IP process, request the termination of self-direction and his or her Self-Directed Support Agreement and individualized budget. Individuals seeking termination may choose an alternative support service. The case manager, support broker or regional designee (depending upon the agency) discusses with the individual/family all the available options and resources available, updates the IP, and begins the process of referral to those options. Once the new option has been identified and secured, the case manager, support broker or regional designee will fill out the form for termination of their individual budget. The form is sent within 10 business days to the VFEA, Resource Administrator or regional designee, and the regional fiscal office representative in the case of DDS and central office in all other cases. In the absence of a regional fiscal office representative for DDS, the form is sent to the appropriate central office.

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Each individual who self-directs by hiring his or her own workers has an Agreement for Self-Directed Supports describing the expectations of the participant. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self Directed Supports. Key terms are:

1. To participate in the development and implementation of the Individual Planning Process.
2. Funds received under this agreement can only be used for items, goods, supports, or services identified in the service recipient's individual plan and authorized individual budget.
3. To actively participate in the selection and ongoing monitoring of supports and services.
4. To understand that no one can be both a paid employ and the employer of record.
5. To authorize payments for services provided only to the recipient according to the individual plan and budget.
6. To enter into an agreement with the provider agency/agencies or individual support worker(s) hired. The agreement is outlined in the Individual Family Agreements with Vendor and Employees an identified the type and amount of supports and services that will be provided.
7. To submit timesheets, receipts, invoices, expenditure reports, or other documentation o the required forms to the fiscal intermediary on a monthly basis or within the agreed upon timeframe.
8. To review the VFEA expenditure reports on a quarterly basis and notify the case manager, broker and VFEQ of any questions or changes.
9. To Follow Cost Standards and Costs Guidelines for the Department for all services and support purchased with the allocation.
10. To get prior authorization from the Department to purchase supports, services, or goods from a party that is related to the individual through family, marriage or business association.
11. To seek and negotiate reasonable fares for services and reasonable costs of items, goods, or equipment, and to obtain three bids for purchases of items, equipment, or home modifications over \$2500.

12. Any special equipment, furnishings, or item purchased under the agreement are the property of the service recipient and will be transferred to the individual's new place of residence or day program or be returned to the state when the item is no longer needed.
13. To participate in the Department's quality review process.
14. To use qualified vendors enrolled by the Department.
15. To ensure that each employee has read the required training materials and completed any individual specific training in the IP prior to working with the person.
16. To offer employment to any new employee on a conditional basis until the criminal history background check, driver's license check and department abuse Registry Check has been completed. Anyone on the Department Abuse Registry cannot be employed to provide support to the individual.
17. To notify the case manager/broker when the individual is no longer able to meet the responsibilities for self-directed services.

The individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under State and federal law. Breach of any of the above requirements with or without intent may disqualify the individual from self-directing services.

An agreement for self-directed supports can be terminated if the participant does not comply with the agreed upon requirements. The case manager, social worker, or care planner would coordinate the transition of services and assist the individual to choose a qualified provider to replace the directly hired staff.

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

All 700 enrollees are expected to self-direct their one-time transition funds. The original 105 estimate included in Appendix A were based on persons self directing in the proposal's original universal waiver and other qualified plans. It is updated below and in Appendix A based upon the budget estimates in Appendix C.

The budget estimates for the Chronic Care, Mentally Ill, ABI, and PCA waiver include the following:

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	Number of Participants	Number of Participants
Year 1	N/A	N/A
Year 2 - 2008	3	0
Year 3 - 2009	60	8
Year 4 - 2010	92	24
Year 5 - 2011+2012	156	60

Participant Employer

a. **Participant – Employer Authority** (Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)

i. **Participant Employer Status.** Specify the participant’s employer status under the demonstration. Check each that applies:

<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</i>
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and State law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant’s representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

<input type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
<input type="checkbox"/>	Hire staff (common law employer)
<input type="checkbox"/>	Verify staff qualifications
<input type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:

<input checked="" type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits
<input checked="" type="checkbox"/>	Schedule staff
<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff
<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)
<input checked="" type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other (<i>specify</i>):

b. Participant – Budget Authority (*Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b*)

- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input checked="" type="checkbox"/>	Reallocate funds among services included in the budget
<input checked="" type="checkbox"/>	Determine the amount paid for services within the State’s established limits
<input checked="" type="checkbox"/>	Substitute service providers
<input checked="" type="checkbox"/>	Schedule the provision of services
<input checked="" type="checkbox"/>	Specify additional service provider qualifications
<input checked="" type="checkbox"/>	Specify how services are provided,
<input checked="" type="checkbox"/>	Identify service providers and refer for provider enrollment
<input checked="" type="checkbox"/>	Authorize payment for demonstration goods and services
<input checked="" type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

- ii. Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Initial funding range is provided by the Regional Planning and Resource Allocation Team (PRAT) based on Level of Need Assessment for persons served by DDS. For all others, the funding range is determined by central office staff after assessment is complete. Within that allocation individuals design an Individual Budget to support the outcomes identified in the IP. The resource allocation ranges derived from analysis of past utilization and costs for services used by like individuals based on assessed level of need. The participant can direct the entire budget for waiver goods and services as the

participant chooses.

- iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The PRAT or central office of the operating unit provides the individual with the resource allocation based on their assessed Level of Need in writing. Following the development of the IP, the individual may request additional funding based on identified needs. For DDS requests for additional funding are reviewed by the regional PRAT, or may go to a regional or State level utilization review process depending upon the amount of funding requested beyond the initial funding range. Requests for additional funding from persons served by other operating agencies, direct their request to central office staff. Any denial of service/funding levels is communicated in writing by the Central Office Waiver Policy Unit regardless of the operating agency and includes the formal notice and requests for a Fair Hearing. This same process applies any time an individual requests an increase in approved funding levels.

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

<input checked="" type="checkbox"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input type="checkbox"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The VFEA monitors expenditures and alerts the waiver participant and Department's support broker/case manager of any variance in line items prior to payment that exceed the quarterly budgeted amount for the specific line item where the variance occurred.

The VFEA has a system to verify that the service or support or product billed is in the authorized Individual Budget prior to making payment. The VFEA is responsible to cover out of its' own funds any payments that exceed what the State has authorized in the Individual Budget.

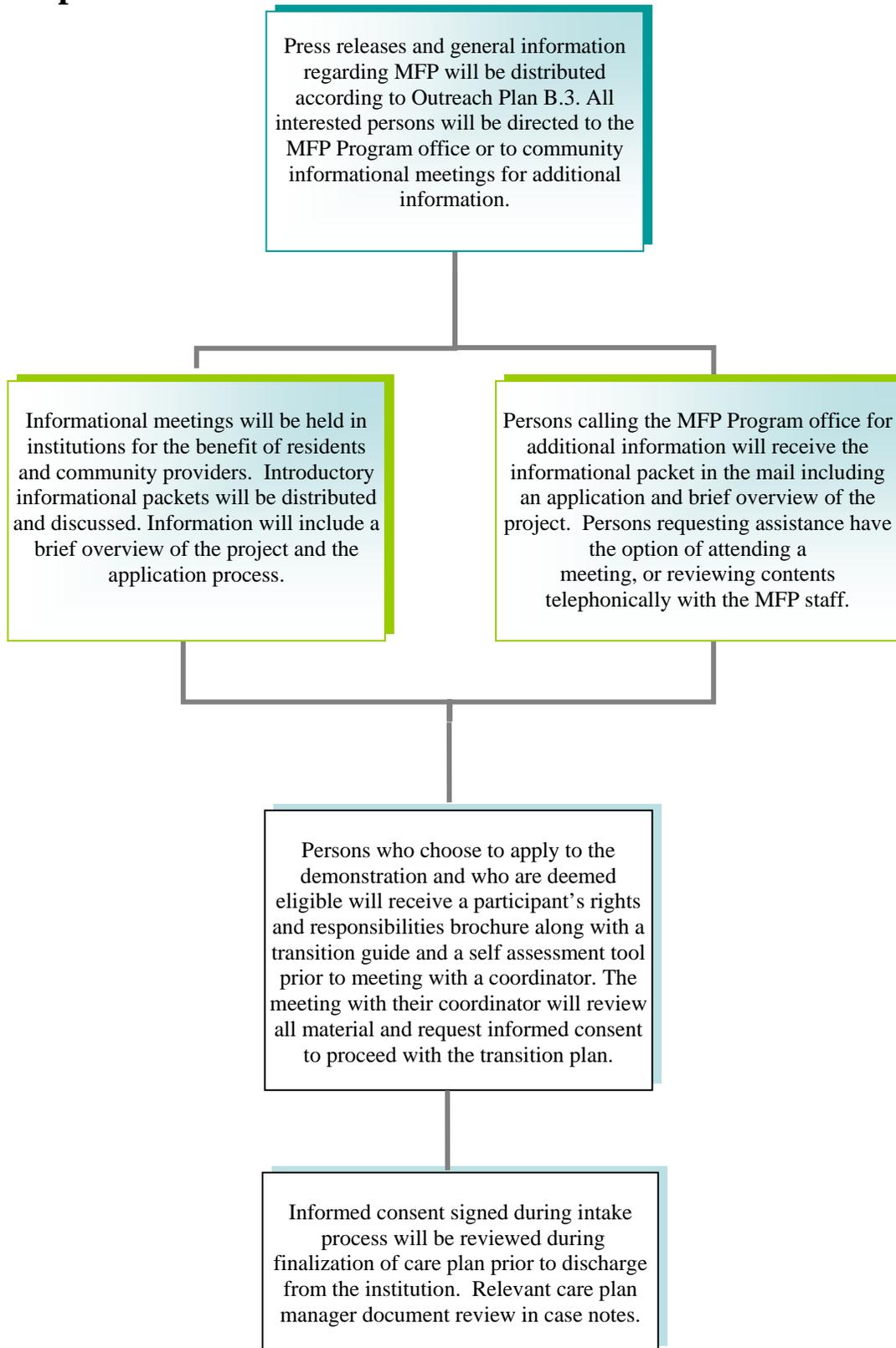
Monthly and Quarterly Utilizations Reports:

Each DDS region has a regional contact person to whom the VFEA sends the Quarterly Utilization Reports. Each region has an internal system for distribution and review of these reports. In addition to the quarterly expenditure report the participant and the case manager also receive a monthly expenditure report. The reports are due the 25th day of the following month. The DDS case manager/broker monitors the monthly expenditure reports, and is responsible to review the expenditure reports against the approved IP and budget on at least a quarterly basis to monitor for

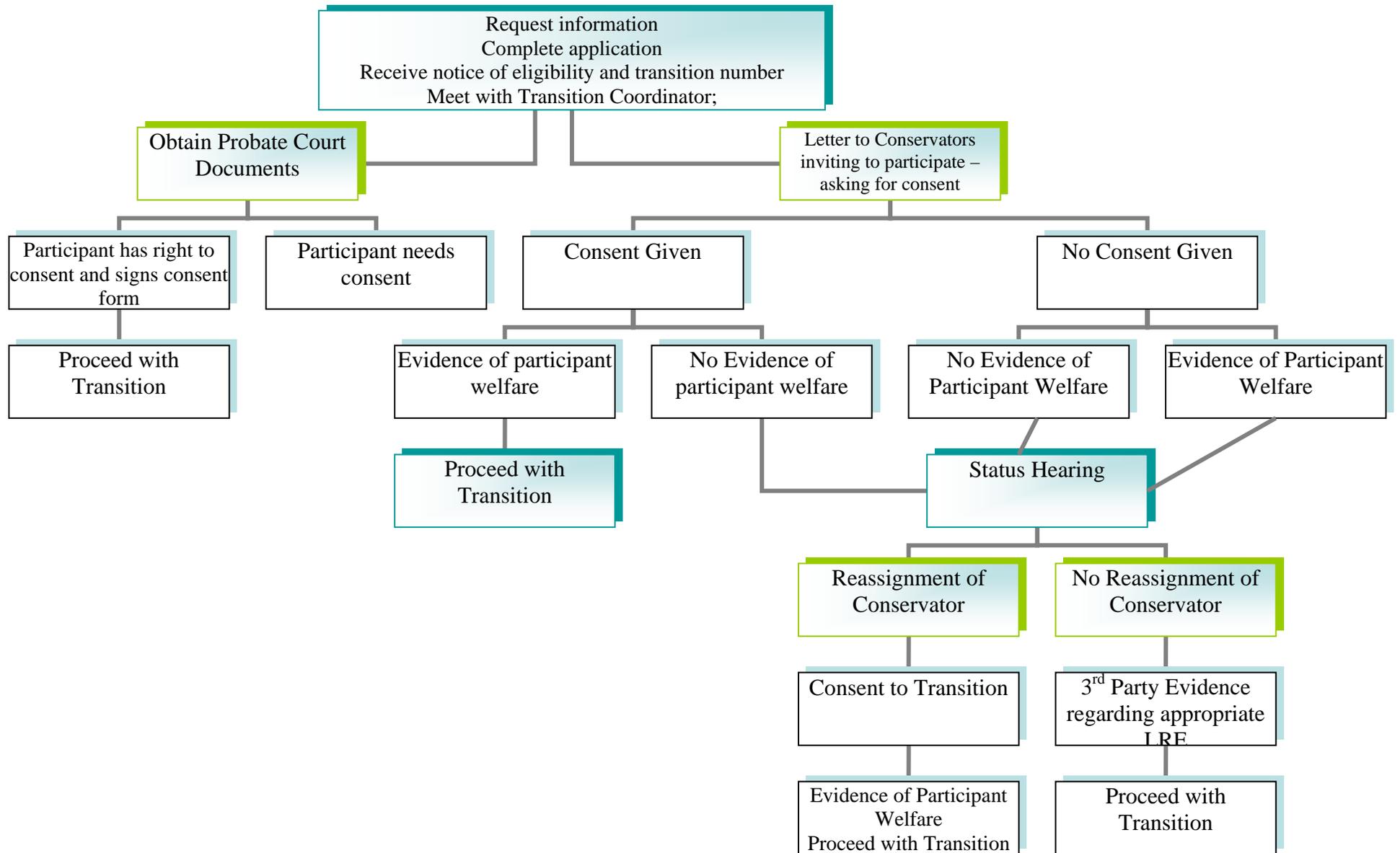
under/over utilization. The region administrator reviews the quarterly reports for utilization and follows up with the case manager/broker when there are significant gaps in service. Similar safeguards are in place in other agencies but the process is a central office function.

Appendix B: Outreach

Informing about Rights and Responsibilities



B.2 Informed Consent and Guardianship



Sample letter to residents

Dear Sir,

The Department of Social Services invites you to an upcoming informational meeting hosted by your Resident's Council on [fill in appropriate date]. The meeting is designed to share with you information about the State's Money Follows the Person Demonstration. The purpose of the Money Follows the Person Demonstration is to design a program that offers you more control over where you live and receive services. This is a very important meeting that may benefit you. We hope that you will consider attending to hear about your options.

DRAFT Outreach brochure

“I lived in a nursing home for 20 years, now I live in the community and work at a day care center at my church.”

Photo

Connecticut Department of Social Service
Money Follows the Person Rebalancing Demonstration

Services to help you move from an institution to the community for people who:

- ❖ Have lived in an institution for 6 months or more;**
- ❖ Are eligible for Medicaid;**
- ❖ Are interested in moving to the community rather than living in the institution.**

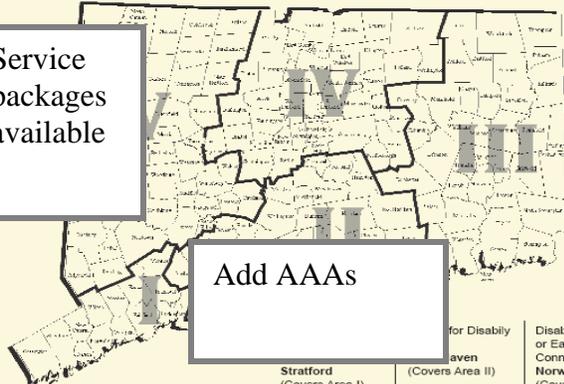
Call today 1 – 800- XXX-XXXX

“If I did it, you can do it.” Photo

(Other side Spanish)

"My Community Choices" Contact Information

Service packages available



Add AAAs

For more information, call 1-800-261-3769 and speak to a staff person from your local center for independent living.

Project Administration
The Connecticut Association
of Centers for Independent Living
Hartford
1-860-656-0430

Stratford
(Covers Area I)

Independence
Unlimited
Hartford
(Covers Area IV)

for Disability
aven
(Covers Area II)

Independence
Northwest
Naugatuck
(Covers Area V)

Disabilities Network
or Eastern
Connecticut
Norwich
(Covers Area III)

Have you lived in an institution for 6 months or more?

Do you know someone who has?

You should know about Money Follows the Person.

Marie chose to live in the community.



I am 55 years old. 17 years ago I had a stroke. At first, I was in a hospital. Then I moved to a nursing facility. For a long time, I needed the help and support the facility provided. One day, I met the Transition Coordinator from the local Center for Independent Living who told me about "My Community Choices." I chose to move back into the community. It wasn't easy, but the Coordinator from the Center helped me.

I now live in a small town. In my community, I've regained the freedom to live my life as I choose. The hardest part was finding a place to live and the help I need to take care of myself. Today a home health agency provides that help. Family, friends, and neighbors are also here to support me. "My Community Choices" became reality for me.

"My Community Choices" provides:

Outreach to Residents	Materials to inform individuals about their options for living in the community and how they can be part of their own transition
Peer Support	Talk with someone who has similar life experiences.
Outreach to Professionals	Materials and workshops to inform legal, medical, and social service professionals.
Common Sense Fund	Funds to help pay short term expenses associated with transition
Transition Coordinators	One to one assistance to help plan and implement a move to the community including coordination of community based supports and services
Housing Support	Assistance finding a home and identifying government rental resources.
Steering Committee	People who live in nursing homes or who recently moved out help design and monitor the "My Community Choices"
Materials Available	Self assessment tool, transition guide, housing resource guide.

**For more information call 1-800-261-3769
and ask for "My Community Choices."**

Philosophy

The independent living philosophy guides the development and implementation of "My Community Choices." Independent living does not necessarily mean doing things for yourself. It means having control over your own life.

Add self-determination for Chronic Care

State

Update for facility types other than SNFs

Outreach to provide housing options for people around the state. Centers for independent living are organizations designed and operated within a local community by individuals with disabilities and provide an array of independent living services.

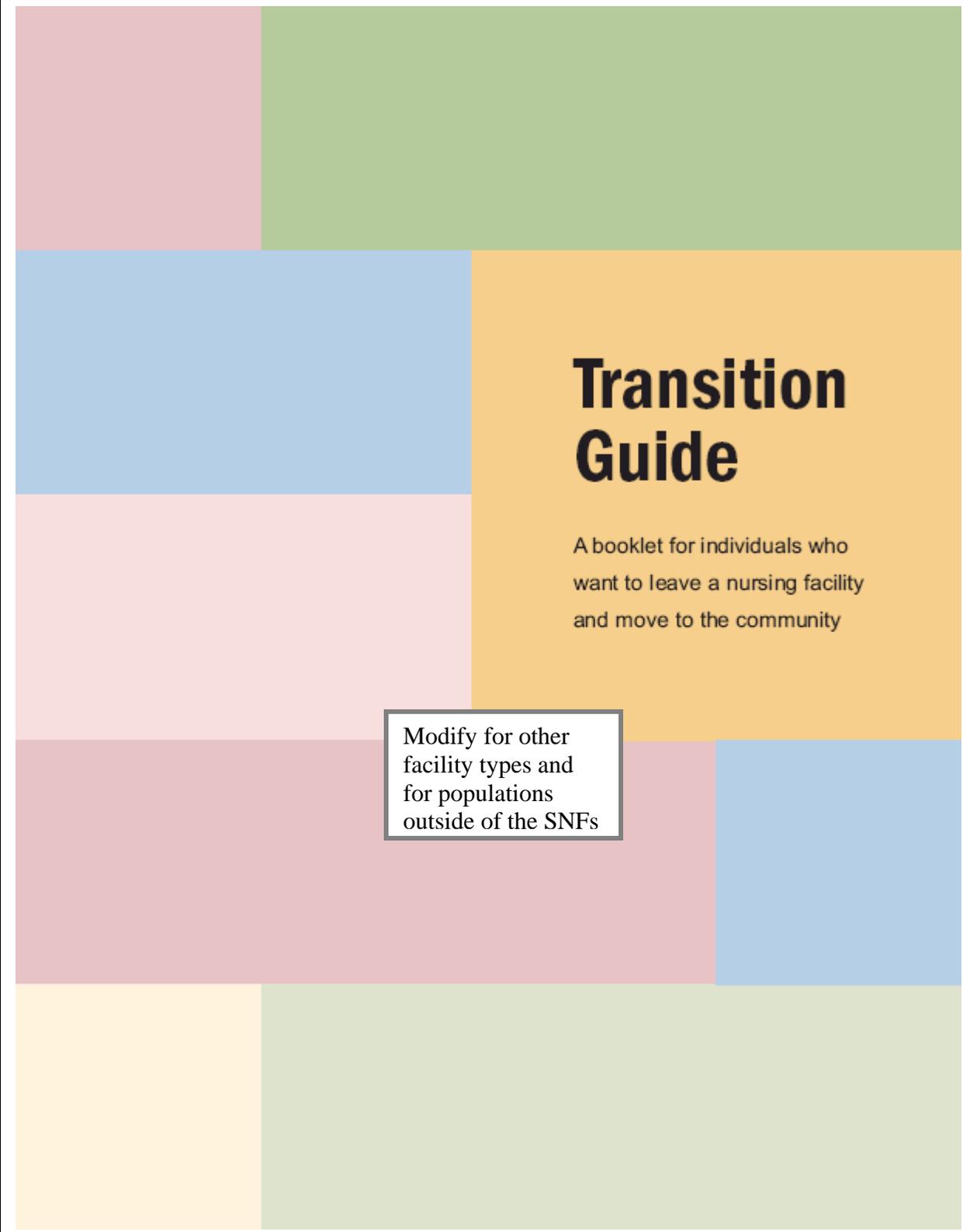
A publication of the CT Nursing Facility Transition Grant

Connecticut Department of Social Services

CT Association of Centers for Independent Living, Inc.

Funding provided by the Centers for Medicare and Medicaid Services

Photo by Arlene Johnson
Brochure layout by Tina Encarnacion



Transition Guide

A booklet for individuals who
want to leave a nursing facility
and move to the community

Modify for other
facility types and
for populations
outside of the SNFs

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The Nursing Facility Transition Project (NFTP) is a three (3) year grant with two (2) major goals:

- Create a system for individuals living in nursing facilities who want to move (or transition) to the community with the supports they need, and;

- Demonstrate the effectiveness of the system by assisting one hundred and fifty (150) individuals to transition from nursing facilities to the community.

The project is funded by a grant from the Centers for Medicare and Medicaid Services ([CMS]; formerly Health Care Financing Authority [HCFA]). The state in turn has contracted with the CT Association of Centers for Independent Living (CACIL) to implement the project.

This booklet is a publication of the Project. It is a "how-to" book for people who want to move from a nursing facility to the community. This condensed booklet will give you basic information to plan your move to the community and get the supports you need. It provides a very basic overview of the Transition Process. A more detailed version, with all the forms and information discussed in this booklet, is available by calling (860) 656-0430. The self assessment can be found in the back of this booklet.

Who can help you?

Your Resource Team

The first people that individuals planning to move out of a nursing facility often work with are the facility staff, community people who come to the facility for various reasons, and others with whom they may have contact. Remember: As things change, people come and go from your life. Continue to build your team with new people who can add to your pool of resources.

A Circle of Support

Gradually as the relationship with your Resource Team changes and grows, some people in particular may become a real source of support. You may ask them to meet with you and work as a team on issues and needs that arise. Within the Independent Living Movement, these people are often known as a "Circle of Support". The people who become part of your Circle of Support are usually people who will be there for the long haul. They are probably not individuals who routinely assist you or do tasks and errands for you, though at times they may offer. Their role is truly informational, advisory and supportive.

Peer Support

People who have similar experiences can be especially helpful. Sometimes it is

helpful to seek out others who have been where you are or are facing the same challenges you are.

Advocates and Transition Coordinators

Centers for Independent Living (CILs) are disability rights organizations which provide four basic services:

- Advocacy
- Information and Referral
- Peer Counseling
- Independent Living Skills Training

In Connecticut, each CIL provides Assistive Technology services. The CILs are also involved in the Nursing Facilities Transition Project and have a 'Transition Coordinator', hired as part of the project. CILs have traditionally taken an active role in helping people leave institutions and move to the community. Their staff 'Advocates' are also an excellent resource for people who wish to leave a nursing facility. There is no charge for their services.

Ombudsman — The Connecticut Long Term Care Ombudsman Program is designed to protect the health, safety, welfare and rights of long term care residents by: investigating complaints and concerns made by residents, or on behalf of

residents, in a timely and prompt manner, and bringing residents to the forefront to voice their concerns directly to public officials on issues affecting their lives.

Support People — These are the people who actually assist you on a day to day basis in the community. They may be aids or homemakers provided by a home health care agency, a case manager, a coach provided through a state agency (example: DMHAS, or DMR) or someone hired by you either privately or through a State program such as the PCA or ABI Waiver.

Personal Managers — One other “people resource” that some individuals have also found to be helpful is someone who can work for/with them to manage or carry out such tasks as placing ads for Personal Assistants or helping arrange backup coverage. These assistants are often referred to as Personal Managers. Unfortunately, in Connecticut as we write this booklet, there is no funding resource to provide or pay for these assistants. Circles of Support, Advocates and Transition Coordinators at your local CILs have found some creative ways to obtain this type of assistant, including, but not limited to funding from private community sources such as foundations and faith based organizations, and volunteers.

A Circle of Support or your local CIL may be able to help with finding the right person.

Note: If you have a court appointed conservator, or guardian, they were appointed by the court for a variety of reasons and may have either limited or almost unlimited authority to make decisions for you. The CT State Office of Protection and Advocacy has a booklet that may be helpful in understanding the role of your conservator or guardian.

For more information on Guardians and Conservators, see the Self-Help booklets; “Conservatorship of Person and/or Estate” and/or “Guardianship for Persons with Mental Retardation”. Both booklets are published by the CT State Office of Protection & Advocacy (P&A). Copies may be obtained by calling: (V/TDD) 1-800-842-7303. Persons with speech related disabilities may use CT Speech to Speech Relay which can be accessed by calling 711. P&A can also be reached by e-mail at: OPA-Information@po.state.ct.us

Designing Your Transition Plan

A transition plan is like any other plan. It is a guide or a road map to your destination. Can you leave a facility and move to the community without a plan? Yes, but our experience is that your best chance for success is to have a plan, so that you stay focused on your goals and avoid difficulties or a return to a nursing facility.

Every plan will be different, because it all depends on who you are. A good plan will be built around your individual needs and goals. We have found that there are 9 major planning pieces to consider when transitioning to community life.

1. Self Assessment: Understanding Your Situation, Goals & Needs
2. Personal Finances and Resources
3. Funding and Benefit Programs
4. Housing
5. Daily Supports for Living Independently
6. Health Services, Supplies and Equipment
7. Transportation
8. Social, Faith, Recreation
9. Work/School/Other Activities

One final note: Any plan is only as good as the work that goes into it. It is a starting place. To be effective a good plan must

also be reviewed and revised periodically. The CT Nursing Facility Transition Project has developed an outline for a Transition Plan. If you would like a copy, contact the Project at (860) 656-0430.

First Steps: Where to start? What to do?

1. Get in touch with your Resource Team and let them know you are planning to transition and would like their help.
2. Perform a Self-Assessment. Please refer to the self-assessment form on page 17. Also, through the entire transition process, when something important to you comes to mind regarding your needs or your situation, bring it up, or make a note of it, so you can discuss it later. It may be very important.
3. Design your plan. After completing the self-assessment you and your resource team can then determine which pieces of your plan you already have in place, and which pieces of your plan you need to build.

Right now, you may feel that you just want to get out of the institution, no matter where

or how. This is very natural. Remember though, you deserve to have a good life once you are in the community. We encourage you to take the time to plan and get the supports you need in place. In developing this booklet we recognize that no two people or situations are alike. Some people may want all the information about the entire process of relocating from

a nursing facility to the community, before they begin. Others may want just a little information. Some may want only specific pieces of information. Use this Booklet in whatever way serves you best. Work from beginning to end to build a plan, or just refer to the sections you feel are helpful. Use everything we have provided or only the pieces you need.

Steps in Designing Your Plan

1: Self-Assessment

A wise person once said — “Know Yourself” — this is especially important if you are attempting to make a major life transition such as moving from a nursing facility to the community. Knowing yourself means knowing your needs and desires. It means knowing the risks you are willing to take, knowing how much you need to be around people and many other things. Thinking this through can help you avoid issues that might cause problems if you don't deal with them early on. Remember: Examining your needs is not a one-time event, but an ongoing process.

You may have already completed the NFTP Self-Assessment. If so, now is a good time to review it, and update any information that may have changed. If you have not completed this assessment before, this is a

good time to complete it. Please refer to the self-assessment form on page 17.

2: Personal Finances and Resources

The first building block in planning your move to the community is to determine the money you have available to work with as you build your plan. Now is the time to get an accurate picture of your finances. Most likely your major source of income is Social Security Benefits. If you do not know what your Social Security benefits are, you can find out by calling a toll-free number, 1-800-772-1213. It operates from 7 AM to 7 PM, Monday to Friday. If you have a touch-tone phone, recorded information and services are available 24 hours a day, including weekends and holidays. People who are deaf or hard of hearing may call a toll-free “TTY” number, 1-800-325-0778,

between 7 a.m. and 7 p.m. on Monday through Friday. Have your Social Security number handy when you call.

If you have savings accounts or other resources, now is the time to find out the value of these accounts. Contact your bank or ask the Social Worker at your facility to assist you in obtaining this information. This is also the time to be sure you have access to your important papers.

Note: Once you have all this information, it will be important to see if there are any regular or periodic automatic payments being made from your account, such as Medicare Premiums. If you do not have a bank account, it may be helpful to establish one. If possible, arrange for automatic deposit of your benefits before you leave the facility.

Your Birth Certificate and Social Security Card will be needed to transition. If you cannot locate these important papers, you need to get copies.

This is also the time to get a copy of your Credit Report. If there are problems, Consumer Credit Counseling Services provides confidential in-person and/or telephone counseling, money management and budgeting skills, debt repayment planning assistance and educational seminars on financial management and

credit issues. They can be reached at 1-800-450-2808.

If you have unpaid bills from the gas, electric or phone company, now is the time to find out what the status of these are and talk with your Resource Team or Circle of Support about what can be done.

There are other issues including, but not limited to, bankruptcy, past criminal record, drug or alcohol abuse, or evictions that may have a definite impact on your ability to access some programs, such as housing. It is important that the people who are assisting you know about these. The sooner you let them know about these types of problems, the sooner they can begin working with you to help identify solutions.

3: Funding and Benefit Programs

In the community, you may be eligible for a variety of programs that help people. These include a variety of State programs that assist with basic needs; food, medical needs, and other types of assistance for living in the community. There are also State waiver programs which provide services in the community rather than in the nursing facility. These include the Acquired Brain Injury Waiver, the Personal Care Assistance Waiver, CT Home Care Program for Elders, the Katie Becket Model

Waiver and the DMR Waiver. Programs such as the State's Rental Assistance Program (RAP) assist with housing. A summary of State Medicaid and related Programs is available from the Department of Social Services (DSS). Call DSS at 1-800-842-1508 and ask for the booklet "CT DSS Medical Programs: Aged, Blind and Disabled."

In summary, we recommend making a list of the services you feel you might need, any programs you think you might be eligible for and any questions you may have. The purpose is to build a body of information to use in working with your resource team in

exploring and obtaining the support programs and services you need.

Finding the Funding and Benefit Programs you need.

The programs and services provided through the State are different when you live in the community than when you live in a nursing facility. Applications must be filed for various programs before you leave the facility to be sure they will "kick in" when you move to the community.

Below is a short listing of State Programs:

Department of Social Services (DSS)1-800-842-1508
State Rental Assistance and Section 8: DSS . 1-800-842-1508

Self-Determination for Persons with Mental Retardation, and the DMR Waiver:
Department of Mental Retardation (DMR) . . . 1-860-418-6000

Mental Health and Addiction Services:
Department of Mental Health and Addiction Services (DMHAS) 1-800-446-7348

Assistance with Work/Return to Work Issues and Needs
Bureau of Rehabilitation Services (BRS) 1-800-537-2549

Assistance with Issues Related to Blindness
Board of Education and Services to the Blind (BESB)1-800-842-4510

Assistance with issues related to Deafness and Hearing Loss
Commission on the Deaf and Hearing Impaired 1-800-708-6796

(State Programs continued on next page)

(State Programs continued from previous page)

For: Personal Care Assistance (PCA) Waiver and Acquired Brain Injury (ABI) Waiver

Contact your local DSS Office:

Bridgeport (203) 551-2700
Danbury (203) 207-8900
Hartford (860) 723-1000
Manchester 1-800-859-6646 . . or . . (860) 647-1441
Middletown 1-800-388-3515 . . or . . (860) 704-3100
New Britain (860) 612-3400
New Haven (203) 974-8000
Norwalk (203) 551-2700
Stamford (203) 251-9300
Torrington 1-800-742-6906 . . or . . (860) 496-6960
Waterbury 1-800-842-1508 . . or . . (203) 597-4183

For the Katie Becket Waiver

Contact DSS Central Office 1-800-445-5394

To apply for the CT Home Care for Elders Program

Call 1-800-445-5394

There are a number of guides and resources available about programs and services in CT.
The following are the ones we consistently find most helpful:

Programs that Help People in CT 1-860-951-2212
Published by CT Light & Power & The Connecticut Association For Human Services

CT InfoLine – available anywhere in CT by dialing 211

Disability Resources in CT 1-800-842-7303
Published by the CT State office of Protection & Advocacy for Persons with Disabilities

Assistance for individuals with speech or hearing loss:

TDD/TTY 1-800-842-9710
RelayCT Speech to Speech Relay 1-877-842-5177

4: Housing

Your home in the community is the foundation for your being able to live independently. It is important to begin to explore housing needs and availability very early in the transition process. Unfortunately, there is a serious lack of affordable, accessible housing in many areas of the State.

A realistic budget is important. How much can you afford for living expenses? Generally, one third of your income for your housing expenses is a good guideline. This will need to include your utilities if they are not included in the rent. You may be eligible for assistance with some of your housing related expenses.

Affordable Housing

You may be eligible for rental assistance, which can substantially lower the amount of money you spend on housing. Your ability to qualify will depend on your income or the income of the household if you live with one or more other people.

Use every resource available to you in finding housing. Tell neighbors, friends, family, etc. what you are looking for. If you belong to a church or other organization, let them know. Check the classified ads in your local paper. Most newspapers are available at the library and on-line. HUD and many local housing authorities are now on the internet.

A good place to begin is at HUD's web site: <http://www.HUD.gov/index.html>. If you do not have internet access, ask friends and family who do for help. In addition, many local libraries have free internet access.

Once you have an idea of what your housing needs and resources are, you also need to consider other factors, such as obtaining furnishings, moving expenses, security deposits and requirements for paying the first (and sometimes last) month's rent "up front." The State Department of Social Services (DSS) may be able to assist with security deposits. Call DSS early in your search to see if this is an option for you. You must also consider if there is a need for modifications, such as widening of doors, and how to fund this.

You need to be aware that once you find housing the landlord will most likely require a credit check and may require references from previous landlords. If you have credit problems, Consumer Credit Counseling Services may be of assistance. They can be reached at: 1-800-450-2808.

If you apply for Public Housing or Section 8, it is important to realize that you will be denied if you have been convicted of a felony, have ever been evicted from public housing, have had Section 8 Voucher withdrawn due to violation of the Section 8 Regulations or have been convicted of the

manufacturing, use, distribution, or sale of illegal drugs.

Waiting lists may seem discouraging. Often you may be told that there is a 6-month to 2-year waiting list, but if it is something you would consider, apply anyway! Remember: waiting periods are only estimates. It could be longer or shorter. You might have to take something less desirable at first but if you are on the waiting list for something better, in time you will move up on the list, creating an option if you have not been successful in locating housing through other means.

If you apply for public housing: (1) Follow up and make sure the application was received and that all the necessary information was provided. Ask how often you can call to check your application status. Be sure to follow up with periodic calls to see that your application is still active, and where you are on the list. (2) Be sure to find out how long they will hold your application---you may need to renew it on a regular basis. (3) If your circumstances change, be sure to update your application by phone and follow up with a letter.

Periodically you will receive requests for additional information or to verify that you are still interested. It is very important that you reply. It may also be helpful to request that a friend, advocate or family member receive a copy of any written communications.

Creative, Non-Traditional Housing Options

Due to the shortage of affordable, accessible housing, you may need to be creative in finding a solution to meet your particular housing needs. You may also need to enlist the help of agencies that offer creative problem solving around housing issues. Some agencies that may be able to help include:

- Centers for Independent Living – see last page
- Co-Op Initiatives (860) 724-4940
- Connecticut Home of Your Own Initiative. . . (860) 724-4940

Habitat for Humanity

- New London (860) 442-7890
- New Haven (203) 785-0794
- Hartford. (860) 541-2208

Home Modifications:

- Community Development Block Grant (CDBG). (860) 240-4800
- Veterans Administration (800) 447-0961
- Bureau of Rehabilitation Services: (BRS) (800) 537-2549
- Corporation for Independent Living: (CIL) (860) 563-6011
- Americans Homefront Program 1-800-887-4673

For more information, call 1-800-261-3769 and ask for "My Community Choices."

5: Daily Supports for Living Independently

Living independently doesn't mean you do everything without the help of others. Most people rely on others and have others who rely on them. The key issue is having control over the type of services you receive and how they are delivered.

If you have significant needs, it is critical that you be able to work with a variety of different people who may be providing you with the supports you need. If you need hands on assistance or help in managing your home, you may be hiring, supervising and even at times firing the people who provide your services. If you need assistance with managing the complexities of daily life you may have a case manager or someone who assists you with following through on things you need to get done. Even so, it is your life and even if you need help in managing it, ultimately you must be the person in control.

Assistive Technologies such as power wheelchairs, devices that can communicate for you or environmental control units which control electrical devices such as lights and fans need to be acquired well before you leave the facility so that you have time to learn to use them effectively. This is the time to begin exploring these. A copy of the booklet "Enhance Your Independence with

Assistive Technology" is available from the CT Tech Act Project: 1-800- 537-2549.

One other resource appropriate for some individuals is "service animals". Just as "Seeing Eye dogs" are trained to assist individuals with loss of vision, these animals are trained to pick up or retrieve objects, open doors and a multitude of other tasks. Your local CIL can assist in exploring this resource further.

Where else can you go for services?

- The State agencies responsible for various programs are another resource (Most of the information is on the internet at the State of CT's Web Site: <http://www.state.ct.us/>) - the social worker at your facility, and Advocate or a Transition Coordinator from your local CIL from the NFTP can help get the information.
- The Dept. of Mental Health and Addiction Services (DMHAS) may be a resource for persons with serious and persistent mental illness and/or substance abuse problems. For general information, please call 1-800-446-7348 or see their website: <http://www.dmhas.state.ct.us>
- The Department of Mental Retardation (DMR) provides supports and services for persons with mental retardation who want to live in the community. There are also a variety of services and supports that are provided through contracts with private providers. Contact DMR at (860) 418-6000 for more information.

- Individuals over the age of 65 may receive services under the CT Home Care Program for the Elderly (CHCPE). Contact CHCPE at 1-800-445-5394 for more information.
- The CT Association of Personal Assistants (CTAPA, P.O. Box 316; Manchester, CT 06045-0316, or on the web at: info@ctapa.org) provides a support system for personal assistants as well as outreach and advocacy for personal assistants around issues such as benefits and wages.
- Allied Community Resources, Inc. (V/TDD) (860) 741-3701 – Consumers in the PCA and the ABI programs receive training and assistance from Allied on the legal requirements and forms which must be filed as part of being a household employer. Training includes documentation and other issues in recruiting, hiring, training and supervising their personal care assistants. Allied assists the consumer in filing all of the necessary IRS applications and paperwork to become an employer, and maintains a registry of PCAs which may be used by consumers for recruiting purposes. The registry is available only to individuals on or applying for these programs. Allied can also provide additional resources in terms of training around issues of recruiting and supervising, if these are needs of the consumer.
- If you are not eligible for these programs there are still alternatives such as bartering room and board with someone in exchange for support or home sharing

with someone who has similar needs so you can both stretch your resources. Your CIL, your Transition Coordinator, your Resource Team and your own creativity can be your best resources for figuring this out.

- Home care agencies can be a resource in a pinch – check the yellow pages for listings under “Home Health Care”

With some programs (PCA Waiver, ABI Waiver, DMR Self Determination) you, the consumer, hire, train, supervise, and if necessary dismiss the person(s) providing your direct supports.

6: Health Services, Supplies and Equipment

Whether we like to admit it or not, everyone has medical needs and these needs tend to increase with age. They are a main reason most people go into nursing facilities.

These needs can result from the process of aging, a progressive disability, an accident or other condition that leads to situations our former support system can no longer adequately address.

Important

When nursing facility staffs and others look at individuals in nursing facilities and think about whether that person could live in the community, the reality of that person obtaining and managing all of the

supports/services needed on a daily and ongoing basis, often leads them to the conclusion that it is too difficult or not possible. They conclude that the person will not be safe, or will not have their medical or other needs met. Very often these are the most significant factors they see as the reason someone needs to remain in a nursing facility.

Admittedly there is risk involved. For some it may be too great, for others it may be worth the risk when compared to the benefits of living outside the facility. This is not a decision to be taken lightly, but transitioning to the community also must not be automatically dismissed as too risky and unsafe. It is something for you, your medical team and your Resource and Support team to explore. If individuals have significant medical considerations, it does not mean the nursing facility is the only option, it might just mean the individual should choose a community that has a hospital and/or readily available medical services.

Health care in the community is quite different from that in a nursing facility. It is important to fully understand your medical condition and needs so that you have adequate medical support services in place before you leave the facility.

It is also important that if you have needs for specific medical treatments or therapies

that your support team is well versed in how to carry out the necessary procedures.

Finally, durable medical equipment such as transfer benches, wheelchairs, commodes, etc. cannot even be ordered until you have a discharge date. These will be ordered by the facility shortly before you are discharged.

7: Transportation

Unlike most of the statewide programs and services systems you will need to work with, transportation is a regional or local issue.

For example: one town may have accessible public transportation that runs daily until midnight, another may have accessible transportation with limited service routes that end at 6 PM, and a third may not have public transportation at all.

There may be no linkage between transportation systems, so getting from Town A to Town B may be a problem. The CT Office of Protection and Advocacy (P&A) publishes a booklet "Accessible Travel" which gives details of the requirements for local and other transportation under the Americans with Disabilities Act. Copies can be obtained by calling 1-800-842-7303.

For information on local transit systems check the Yellow Pages under "Bus" or call 877-CTRIDES (877-287-4337). Information is also available on-line at [http:// www.ctrides.com](http://www.ctrides.com).

Generally there are three transportation options: (1) Own your own vehicle and drive yourself or hire someone to drive you, (2) Hire someone to drive you in their vehicle or rely on family and friends or (3) Use the available public, paratransit or medical transportation system. Each has its own benefits and problems. And remember, this is New England — it snows here! You will need to consider weather in your transportation planning.

8: Social, Faith and Recreation

The types of recreation and leisure activities in which you participate will depend somewhat on the community in which you choose to live as well as your own preferences. This is an important area to explore early on as some communities may not offer opportunities you consider important.

Many communities have a book or pamphlet available at the town hall that contains information about services and activities available to the people in the community. Also check to see if there is a special listing of the services for the elderly and persons with disabilities.

Many of the people we have talked with who have moved out of nursing facilities have commented on the importance of participating in their community. Loneliness, isolation, lack of contact or interaction with

people not paid to provide their care or service, can make living in the community seem very empty and depressing. Social interaction and recreation can be as important as getting your basic needs met.

9: Work, School and Other Pursuits

Note: if you are retired, this section may still hold some practical advice for you. Many people today work occasionally or part time after retirement. Volunteer work or taking a few classes can also bring some of the advantages described below. Some local colleges allow "seniors" to "audit"; or attend some classes without receiving credit for free!

Activities that result in your earning money have a number of benefits beyond the obvious:

- People who leave a facility may experience isolation, which can lead to dissatisfaction with their new life. Employment or preparing for employment (going back to school) offers a number of benefits that may help avert this situation. These include being out in the community, building a sense of being self-reliant, and connecting with others socially.
- With the growth in technology, work, even for individuals with the most significant disabilities, is possible. Working from home or "telecommuting" for part or all of a job is a real option.
- Working or the pursuit of work, including schooling and other activities which lead

For more information, call 1-800-261-3769 and ask for "My Community Choices."

to work, opens the door to a variety of supports and services such as those offered through the Bureau of Rehabilitation Services (BRS) or the Board of Education and Services for the Blind (BESB). These state organizations can assist with a variety of things from home or vehicle modifications to purchase of assistive technology, if it is connected to a vocational goal.

- Earned income opens the door to some benefits and services such as Medicaid

for the Employed Disabled (MED), a program administered by the CT DSS.

- In considering income as part of the eligibility for benefits, earned income is treated differently, generally in ways that benefit the consumer, from unearned income such as Social Security.
- Work and school can enrich your life and your budget

CT Nursing Facility Transition Project – Contact Information

The map of Connecticut is divided into several regions, each with contact information for local organizations. The regions and their details are as follows:

- in Northwestern Connecticut Contact:**

Independence Northwest
1165 New Haven Road, Ste. 200
Naugatuck, CT
Phone: 203-729-5239
TDD: 203-729-1291
Fax: 203-729-2539
info@independencenorthwest.org
- in North Central Connecticut Contact:**

Independence Unlimited
151 New Park Ave., Suite D
Hartford, CT 06106
Phone: 860-523-5031 W/VO
TDD: 860-523-7001 Auto answers
Fax: 860-523-5003
contactus@independenceunlimited.org
- in Eastern Connecticut Contact:**

Disabilities Network of Eastern Connecticut
28 West Town Street
Norwich, CT 06360
Phone: 860-823-1886
TDD: 860-889-3578
Fax: 860-868-2318
dnet@snet.net
- in Southwestern Connecticut Contact:**

Disability Resource Center of Fairfield County
80 Ferry Blvd
Stamford, CT 06615
Phone: 203-378-6977
TDD: 203-378-3248
Fax: 203-378-2718
info@drcc.org
http://www.drcc.org
- in South Central Connecticut Contact:**

Center for Disability Rights
784-A Campbell Ave.
West Haven, CT 06516
Phone: 203-934-7077
TDD: 203-934-7078
Fax: 203-934-7078
cc7077@aol.com
- or Contact:**

CT Association of Centers for Independent Living
151 New Park Ave., Box 18, Hartford, CT 06106
Phone: 860-856-0430
TDD: 860-856-2353
Fax: 860-856-0496
Email: plord@cacil.net
www.cacil.net

Self-Assessment – Community Living

The purpose of this self-assessment is different from some you may have encountered. It is not about what you can or can not do, but what supports you believe you would need to live in the community. It is to be filled out by you, and is for your use. We hope it will help you figure out what you would need in order to leave a nursing facility and live in the community.

This is about what you know, think and feel about where you now live and where you would like to live. You do not have to send or show the answers to anyone. It is for your use to help you and anyone you want to help plan your future."

A good way to start is to review or think about what help or assistance you get now. What works for you, and what doesn't work?

There are no right or wrong answers.

Community Support Needs:

For each area below, check any help or assistance you feel you would need in the community.

Use the box to the right to describe the type of assistance that would be most helpful or special needs, concerns comments you may have about your needs.

A good way to start is to review or think about what help or assistance you get now. What works for you, and what doesn't work?

a) What is my disability, or what are the things that lead to my being here or keep me here?	
b) How does my disability affect my ability to live independently?	
c) What is my ideal situation (City, Suburbs, Rural, or Alone? Family? Home-share?)	
d) Are there others in my life, family, friends, etc., I could ask to assist in me in moving to the community?	

Community Support Needs, continued:

For each area below, check any help or assistance you feel you would need in the community.

Use the box to the right to describe the type of assistance that would be most helpful, or special needs, concerns, or comments you may have about your needs.

A good way to start is to review or think about what help or assistance you get now? What works for you, and what doesn't work?

I. Personal Financial Resources		
Area	Support Needed	Describe
1. Finances and Personal Affairs	<input type="checkbox"/> Paying Bills <input type="checkbox"/> Financial Management <input type="checkbox"/> Budgeting <input type="checkbox"/> Assistance with Banking <input type="checkbox"/> Resolving Past or Present Credit Issues or Problems <input type="checkbox"/> Legal Counsel	

Notes:

II. Funding and Benefit Programs		
Area	Support Needed	Describe
2. Management of Entitlements, Benefits, etc.	<input type="checkbox"/> Securing and Maintaining Entitlement/Benefits: Applications, Re-determinations, Reporting Requirements <input type="checkbox"/> Other: Describe	
3. Managing Personal Supports	<input type="checkbox"/> Advertising for Personal Care Assistants (PCAs) <input type="checkbox"/> Interviewing, Reference Checking and Hiring PCAs <input type="checkbox"/> Training and Scheduling PCAs <input type="checkbox"/> Planning/Arranging PCAs Back-up As Needed <input type="checkbox"/> Other PCA Issues	

Notes:

III. Housing		
Area	Support Needed	Describe
4. Housing: Accessibility Needs.	<input type="checkbox"/> No Stairs <input type="checkbox"/> Only a Few Stairs <input type="checkbox"/> Wheelchair Accessible Entrance <input type="checkbox"/> Wheelchair Accessible Bathroom <input type="checkbox"/> Accessible Kitchen <input type="checkbox"/> Other	
5. Maintenance of Property or Home	<input type="checkbox"/> Arranging for Heavier House Work, Home Maintenance or Seasonal Chores <input type="checkbox"/> Property Maintenance (Lawn Care, Snow Removal)	

Notes:

IV. Independent Living and Daily Supports		
Area	Support Needed	Describe
6. Meal Planning, Prep./Eating	<input type="checkbox"/> Assistance in Meal Planning <input type="checkbox"/> Assistance with Cold Meal Preparation <input type="checkbox"/> Assistance with Hot Meal Preparation <input type="checkbox"/> Assistance with Eating and Drinking <input type="checkbox"/> Special Diet <input type="checkbox"/> Other	
7. Personal Care:	<input type="checkbox"/> Assistance with Transfers <input type="checkbox"/> Assistance with Daily Grooming <input type="checkbox"/> Assistance with Bathing <input type="checkbox"/> Assistance with Toileting <input type="checkbox"/> Assistance with Dressing <input type="checkbox"/> Other	
8. Getting Ready for Bed.	<input type="checkbox"/> Undressing, preparing for bed <input type="checkbox"/> Night Time Personal Hygiene <input type="checkbox"/> Transferring into bed. <input type="checkbox"/> Other	
9. Night Time Assistance	<input type="checkbox"/> Turning/Repositioning <input type="checkbox"/> Monitoring <input type="checkbox"/> Other	

IV. Independent Living and Daily Supports, continued

Area	Support Needed	Describe
10. Mobility	<input type="checkbox"/> Lifts or Transfers <input type="checkbox"/> Wheelchair <input type="checkbox"/> Power Wheelchair <input type="checkbox"/> Cane/Walker <input type="checkbox"/> Other	
11. Housekeeping	<input type="checkbox"/> Routine Light House Work <input type="checkbox"/> Dusting <input type="checkbox"/> Vacuuming <input type="checkbox"/> Dishes <input type="checkbox"/> Bathroom Cleaning <input type="checkbox"/> Floors <input type="checkbox"/> Other	
12. Laundry	<input type="checkbox"/> Washing & Drying Clothes <input type="checkbox"/> Ironing <input type="checkbox"/> Sewing or Repairing Clothing	
13. Shopping: Groceries/Other	<input type="checkbox"/> Assistance to Make List/Plan Shopping Trips <input type="checkbox"/> Transportation <input type="checkbox"/> Assistance in Stores <input type="checkbox"/> Assistance with Managing Money <input type="checkbox"/> Assistance in Getting Purchases Home <input type="checkbox"/> Assistance with Storing Purchases	

IV. Independent Living and Daily Supports, continued		
Area	Support Needed	Describe
14. Assistive Technology and Medical Equipment (Vents, etc.)	<input type="checkbox"/> Environmental Controls <input type="checkbox"/> Mobility Equipment <input type="checkbox"/> Communication Devices <input type="checkbox"/> Maintenance of Assistive Technology and Medical Equipment <input type="checkbox"/> Other	
15. Child Care/ Parenting	<input type="checkbox"/> Parent Education <input type="checkbox"/> Special Equipment (Accessible Baby Furniture, etc.) <input type="checkbox"/> An Aid or Someone to Assist with Parenting Responsibilities <input type="checkbox"/> Parents with Disabilities Support Group	

Notes:

V. Health Services, Supplies and Equipment		
Area	Support Needed	Describe
16. Medical: Medication, Therapy, Medical Treatments	<input type="checkbox"/> Health Monitoring (Blood Pressure, Blood Sugar, etc.) <input type="checkbox"/> Medication Monitoring <input type="checkbox"/> Medical Treatment (Injections, IV Therapy, Wound Care, etc.) <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Ventilator Support <input type="checkbox"/> Catheter <input type="checkbox"/> Bowel Regime <input type="checkbox"/> Dental <input type="checkbox"/> Assistance with Keeping Medical/Dental Appointments <input type="checkbox"/> Other: Describe	
17. Mental Health - Psychiatric	<input type="checkbox"/> Case manager <input type="checkbox"/> Day Treatment Program <input type="checkbox"/> Social Club <input type="checkbox"/> Job/Vocational Counseling <input type="checkbox"/> Psychotherapy Visits <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	
Notes:		

VI. Transportation

Area	Support Needed	Describe
18. Getting Around Town / Transportation	<ul style="list-style-type: none"><input type="checkbox"/> Accessible Vehicle<input type="checkbox"/> Adaptive driving controls<input type="checkbox"/> Drivers Education<input type="checkbox"/> Personal Assistant to drive<input type="checkbox"/> Public Transportation<input type="checkbox"/> Accessible Public Transportation<input type="checkbox"/> Curb to Curb<input type="checkbox"/> Door to Door	

Notes:

VII. Social, Faith, Recreation		
Area	Support Needed	Describe
19. Counseling/ Peer Support	<input type="checkbox"/> Phone Contact with Others with Disabilities <input type="checkbox"/> Visits from Others with Disabilities <input type="checkbox"/> A Support Network of People to rely on <input type="checkbox"/> Support Group <input type="checkbox"/> Circle of Support <input type="checkbox"/> Formal Counseling	
20. Community Access: Faith Communities, Recreation, Leisure pursuits	<input type="checkbox"/> Transportation <input type="checkbox"/> Public Transportation <input type="checkbox"/> Personal Assistance. <input type="checkbox"/> Housing Located Close to Certain Facilities (Houses of Worship, Library, Recreation Facilities, Theaters, Stores, Parks, Museums, etc.); Describe <input type="checkbox"/> Assistance in Identifying Community Resources <input type="checkbox"/> Other: Describe	

Notes:

VIII. Work School		
Area	Support Needed	Describe
21.Vocational	<input type="checkbox"/> Exploring Work or Schooling Options <input type="checkbox"/> Exploring Impact of Working on Benefits <input type="checkbox"/> Other: Describe	
22. Achieving Your Goals or Dreams	<input type="checkbox"/> Assistance in Identifying or Setting Personal Goals <input type="checkbox"/> Assistance in Planning How to Achieve Personal Goals <input type="checkbox"/> Other: Describe	

Notes:

Now that you have looked at what your needs might be; the following questions will help you think about the future as you begin planning:

What strengths, resources, and qualities do I have that will be part of my success?

What are my fears, concerns, or other things I believe may be a problem?

What can be done to remove or reduce them?

What strengths and resources exist in my family, friends, and communities that will help me succeed?

What else is important to me?

Appendix C: Service Budget

Note: Currently these costs reflect a significant amount of fiscal intermediary cost. However, the specific negotiated amount will change based on an influx of members. Presentation levels are assumed at 100% participation but actual experience could change these results.

Money Follows the Person Demonstration Worksheet for Proposed Budget

Instructions: Please fill in only the cells highlighted in YELLOW. All other cells will autopopulate. Please DO NOT alter any formulas.

State/Grantee:
CT
Grant #:
1LICMF300142
Demonstration Program Title:
MFP

Please express FMAP as a decimal. (example: 68.32%=.6832)		
State FMAP		Enhanced FMAP
FFY 2007	50%	75%
FFY 2008	50%	75%
FFY 2009	50%	75%
FFY 2010	50%	75%
FFY 2011	50%	75%

Populations to be Transitioned (unduplicated count)

Unduplicated Count - Each individual is only counted once in the year that they physically transition.
All population counts and budget estimates are based on the Calendar Year (CY).

	Elderly	MR/DD	Physically Disabled	Mental Illness	Chronic Care
CY2008	10	2	7	5	-
CY2009	85	20	55	41	2
CY2010	78	20	51	41	14
CY2011 and CY2012	94	26	62	54	33
Total Count	267	68	175	141	49
			Total of Population		700

C

Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services are defined in the RFP.

Administration - Normal - costs that adhere to CFR Title 42, Section 433(b)(7); Administrative - 75% - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10); Administrative - 90% - costs that adhere to CFR Title 42 Section 433(b)(3)

Federal Evaluation Supports - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).

Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings attributed to the Enhanced FMAP Rate that could be reinvested into rebalancing benchmarks.

Other - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2011)	Rate	Total Costs	Federal	State
Qualified HCBS		33,200,753	24,900,565	8,300,188
Demonstration HCBS		886,007	664,505	221,502
Supplemental		5,388,513	2,694,256	2,694,256
Administrative - Normal		3,558,596	1,779,298	1,779,298
Administrative - 75%		-	-	-
Administrative - 90%		200,000	180,000	20,000
Federal Evaluation Supports		183,100	183,100	-
Other		-	-	-
State Evaluation		500,000	250,000	250,000
Total		43,916,968	30,651,724	13,265,244

Per Capita Service Costs	56,393
Per Capita Admin Costs	5,369
Rebalancing Fund	2,633,177

CY 2007	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	75%		0	0	Actual Grant Award for CY	1,313,823
Demonstration HCBS	75%		0	0	Total Fed Costs	65,179
Supplemental	50%		0	0	Balance	1,248,644
Administrative - Normal	50%	130,358	65,179	65,179	Award Request for next year	872,140
Administrative - 75%	75%		0	0	Total (Balance + Request)	2,120,784
Administrative - 90%	90%		0	0		
Federal Evaluation Supports	100%		0	0		
Other	100%		0	0		
State Evaluation (if approved)	50%		0	0		
Total		130,358	65,179	65,179		

CY 2008	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	75%	215,803	161,853	53,951	Actual Grant Award for CY	872,140
Demonstration HCBS	75%	37,960	28,470	9,490	Total Fed Costs	872,140
Supplemental	50%	599,440	299,720	299,720	Balance	0
Administrative - Normal	50%	479,396	239,698	239,698	Award Request for next year	
Administrative - 75%	75%		0	0	Total (Balance + Request)	0
Administrative - 90%	90%	100,000	90,000	10,000		
Federal Evaluation Supports	100%	2,400	2,400	0		
Other	100%		0	0		
State Evaluation (if approved)	50%	100,000	50,000	50,000		
Total		1,534,999	872,140	662,859		

CY2009	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	75%	4,302,577	3,226,933	1,075,644	Actual Grant Award for CY	4,755,117
Demonstration HCBS	75%	230,372	172,779	57,593	Total Fed Costs	4,755,117
Supplemental	50%	1,525,705	762,853	762,853	Balance	0
Administrative - Normal	50%	859,707	429,853	429,853	Award Request for next year	
Administrative - 75%	75%		0	0	Total (Balance + Request)	0
Administrative - 90%	90%	100,000	90,000	10,000		
Federal Evaluation Supports	100%	22,700	22,700	0		
Other	100%		0	0		
State Evaluation (if approved)	50%	100,000	50,000	50,000		
Total		7,141,060	4,755,117	2,385,943		

CY2010	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	75%	8,982,740	6,737,055	2,245,685	Actual Grant Award for CY	8,278,435
Demonstration HCBS	75%	230,912	173,184	57,728	Total Fed Costs	8,278,435
Supplemental	50%	1,593,941	796,971	796,971	Balance	0
Administrative - Normal	50%	956,250	478,125	478,125	Award Request for next year	
Administrative - 75%	75%		0	0	Total (Balance + Request)	0
Administrative - 90%	90%		0	0		
Federal Evaluation Supports	100%	43,100	43,100	0		
Other	100%		0	0		
State Evaluation (if approved)	50%	100,000	50,000	50,000		
Total		11,906,944	8,278,435	3,628,509		

CY2011 + CY2012	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	75%	19,699,633	14,774,724	4,924,908	Actual Grant Award for CY	8,115,727
Demonstration HCBS	75%	386,763	290,073	96,691	Total Fed Costs	16,680,853
Supplemental	50%	1,669,426	834,713	834,713	Balance	-8,565,126
Administrative - Normal	50%	1,132,885	566,442	566,442	Award Request for next year	
Administrative - 75%	75%		0	0	Total (Balance + Request)	-8,565,126
Administrative - 90%	90%		0	0		
Federal Evaluation Supports	100%	114,900	114,900	0		
Other	100%		0	0		
State Evaluation (if approved)	50%	200,000	100,000	100,000		
Total		23,203,607	16,680,853	6,522,755		

Appendix D: Informed Consent

State of Connecticut
Department of Social Services
Money Follows the Person Rebalancing Demonstration
Informed Consent Form

I freely choose to participate in the Money Follows the Person program, which will assist me in moving from an institution to a home or to the community. I understand that I must be determined eligible for one (1) of the six (6) service packages to participate in the Money Follows the Person program. I understand that my eligibility for service packages is based on what I need. I understand that my needs will be assessed by an employee of the State of Connecticut or a contractor of the State. I understand that my needs will be reassessed after the first year for continuation services in the State's waiver program. I understand that if my level of care changes and/or my financial status, I may be no longer be eligible for Medicaid services.

I understand that this program may allow me to receive a limited amount of flexible funds for expenses related to my transition from the facility where I currently live to a new home in the community. I understand these funds may be used for furniture, transportation expenses, and other costs directly related to my transition. I understand that these funds may also be used for the purchase of assistive technology. I understand that my transition coordinator will help me access these funds. I understand these funds are available only after I am determined eligible for the Money Follows the Person program and up to 60 days after I transition to the community.

I understand that this program allows me to receive funds to make accessibility modifications to the home in which I plan to live. I understand that this fund is limited and will be distributed as needed on a first come first serve basis.

I understand that agreeing to participate in the Money Follows the Person program has no impact on my eligibility for any other program, meaning that I will continue to receive other services for which I am eligible regardless of my Money Follows the Person program eligibility.

In order to participate in the Money Follows the Person program, I have been informed that I must meet all of the eligibility requirements specific to the Money Follows the Person program, which include six (6) months living in a qualified institution, such as a nursing facility or the Hospital for Special Care, one (1) month of community Medicaid eligibility prior to my date of transition to the community, eligibility for one (1) of the six (6) service packages designed to meet my home and community based needs and finally that I must choose to live in a qualified residence, defined as:

- 1) A home owned or leased by myself or a family member;
- 2) An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which myself or my family has domain and control;
- 3) A residence, in a community-based residential setting, in which no more than 4 other unrelated individuals reside.

As a participant in the Money Follows the Person program I will be asked to complete surveys and interviews about my quality of life. I will still be eligible for services under the Money

Follows the Person program even if I do not complete the surveys. Any information collected will be confidential and used only for evaluation purposes.

If I have any complaints or questions I may contact the Department of Social Services, Medical Care Administration, Money Follows the Person Demonstration; 25 Sigourney Street; Hartford, CT; 06106; or by email at Dawn.Lambert@ct.gov; or by telephoning 1-800-424-4897.

My signature below indicates that I agree to participate in the Money Follows the Person program if I am determined eligible and that any questions that I may have about the program have been answered.

CONSENT

By signing this informed consent, you agree to participate in the Money Follows the Person Rebalancing (MFP) Demonstration. You be given a signed copy of this consent form to keep.

MFP PARTICIPANT	
Printed Name:	
Participant Signature:	
Date Signed:	
Social Security Number:	
Medicaid Number:	
Address:	
Telephone: ()	

MFP LEGAL GUARDIAN/CONSERVATOR	
Guardian/Conservator Signature:	
Date Signed:	
Address:	
Telephone: ()	

CASE MANAGER/SOCIAL WORKER/CARE PLANNER ACKNOWLEDGEMENT	
I have read and explained this document to the applicant. I believe that he/she (or the guardian/conservator, if signed) understood the document.	
Signature:	
Date Signed:	
Address:	
Telephone: ()	

Appendix E: Job Description – Transition Coordinator

Job Title: Transition Coordinator

Hours: Full time; Occasional evenings and/or weekend hours.

Qualifications: Bachelor's degree in human services. Knowledge of the Independent Living philosophy; Knowledge of community resources; strong written and communication skills

Experience: Experience in systems advocacy and community organizing;

Responsibilities:

- 1) Establish relationships with local community providers, local access agencies, local DSS social workers and other organizations;
- 2) Serve as liaison between the providers, access agencies, DSS social workers, other community based organizations and the State's transition program;
- 3) Engage in outreach activities at nursing facilities to inform residents and staff about the transition program;
- 4) Establish relationships with key staff within nursing homes who may assist with identification of individuals who are interested in transitioning;
- 5) Conduct initial interview and complete intake paperwork with persons in nursing homes and/or ICF/MR;
- 6) Assist each participant with the development and implementation of a transition plan;
- 7) Advocate on behalf of the participant;
- 8) Coordinate plans and make referrals to appropriate community resources;
- 9) Maintains and keeps current consumer records; completes and submits all reports on time; and
- 10) Attend all in-services, trainings, meetings, as requested.

Appendix F: Rates and Definitions

Qualified Service Package for Persons with Mental Illness Assertive Community Treatment (ACT)

Definition

Assertive Community Treatment (ACT) is a recovery focused, high intensity, community-based service for individuals discharged from multiple or extended stays in hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated, rehabilitative community support, crisis, and treatment interventions/services that are available 24-hours/7days a week.

ACT includes a comprehensive array of rehabilitative services integrated with medical care, most of which is provided in non-office settings by a mobile multidisciplinary team. The team provides community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings to no fewer than 60 active participants.

The ACT team provides nearly all the treatment needed by the participant. ACT community and clinical services are guided by the participant's strengths and preferences. The service involves an assertive approach, individually tailored programming, ongoing monitoring, variable support, *in vivo* service, relating to participants as responsible citizens, utilizing a variety of community resources and collaborating with the family. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her actual living environment. The team is persistent in engaging the participant, doing whatever is necessary to keep the individual involved in community life and active in treatment.

ACT services are targeted to individuals with the most complex and persistent psychiatric problems (including those with co-occurring psychiatric and substance use disorders) seen among persons living outside institutional settings. ACT service recipients also are likely to have interlocking social, economic and legal problems that complicate their behavioral health treatment. ACT service users often have erratic behaviors, are frequent users of crisis services, are often difficult to engage in care, have poor adherence to treatment plans, have had multiple hospitalizations, have not benefited from the traditional array of community-based services and, were it not for ACT care, would likely require hospitalization or care in some other institutional setting.

Rate: \$35.00/qtr. hr

Provider Qualifications/Conditions for Participation

Certificate: The Joint Commission (TJC).

Other Standards: ACT clinical staff shall hold either a master's degree in a behavioral health-related specialty (may include special education or rehabilitation) to function as a licensed clinical ACT provider. Paraprofessionals on an ACT team must have a bachelor's degree OR have two years experience in the provision of mental health services (may include special

education and/or services to persons with developmental disabilities), OR be a Certified Peer Specialist.

As ACT service provider must meet the State of Connecticut certification standards to provide both Clinical Services and ACT services as defined by the Department of Mental Health and Addiction Services (DMHAS).

Entity Responsible for Verification: DMHAS

Frequency of Verification: At start of services and at recertification.

Unit of Service: 15 minutes

Covered services

ACT services of at least 15-minutes duration provided to the participant by a direct-care member of the ACT team in the participant's home and in other community settings. These services include:

- (1) Mental health services, including:
 - Comprehensive Assessment that contains a psychiatric history, risk assessment, functional history, mental status examination, and diagnosis; and assessments of physical health; use of drugs and alcohol; education and employment; social development and functioning; activities of daily living; family structure and relationships; and environmental supports.
 - Treatment and rehabilitation planning, including a timeline of past events
 - Service coordination.
 - Crisis assessment and face-to-face or telephonic crisis intervention and monitoring
 - Symptom assessment and management.
 - Development of skills for recognizing stressors, and building coping mechanisms and recovery strategies.
 - Medication prescription, administration, monitoring and education (Note: these services may be provided in an office setting).
 - Counseling and psychotherapy.
- (2) Co-occurring substance abuse services, using the Integrated Dual Disorders Treatment (IDDT) model.
- (3) Clarification of goals and motivational support for pursuing goals related to employment, education, community involvement, and use of natural supports (Note: documentation shall be maintained in the file of each participant receiving work and education-related services that such services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- (4) Residential supports, such as motivating the participant to find and lease an apartment, and assistance with tenancy issues and problems.

- (5) Skill building and support for Activities of Daily Living, including:
 - Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving.
 - Other skill development activities directed at reducing disability, restoring functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the waiver Recovery Plan.
 - Social/interpersonal relationship and leisure-time skill training.
- (6) Education, support, and consultation to family members (and significant others) of the participant, provided these activities are directed exclusively toward the treatment of the participant.
- (7) Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator.
- (8) Travel with a participant or family member when the ACT Service provider is also engaged in a qualifying waiver service activity.
- (9) Group treatment, involving not more than four persons receiving care, focusing on any of the activities listed in items #1-G through #5-C, above. (NOTE: Group rates are 30 percent of the individual ACT rate. See applicable rate schedule for details).

Limitations

Coverage of ACT services shall be subject to the following limitations:

- (1) ACT services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.
- (2) ACT services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician who is a member of the ACT team.
- (3) ACT is a comprehensive team intervention with most behavioral health services provided by the ACT team. The Department will not pay for ACT services concurrently with other Medicaid funded behavioral health services except to support a transition period (of up to 30 days) across levels of care. The Department will pay for ACT services provided concurrently with inpatient psychiatric services, detoxification services, opioid treatment, neuropsychological testing, partial hospitalization, day treatment, intensive outpatient treatment, transitional care management, recovery assistance, short term supervision and support, and supported employment services.

- (4) A claim for reimbursement may be submitted for the qualifying waiver services activities of only one direct-care member of an ACT team for services to a participant during a specific time period (i.e., billable unit of time).
- (5) The Department shall not pay for:
 - Time spent by the provider solely for the purpose of transporting participants.
 - Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.
 - Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history.
 - Programs, services or components of services that are not included in the fee established by the Department.
 - Services or components of services provided solely for social, recreational, educational or vocational purposes.
 - Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

- (1) Day-to-day monitoring regarding the participants health and welfare, and problem solving to address concerns.
- (2) Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery.
- (3) Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization of services.
- (4) Completion of progress notes or billing documentation.
- (5) Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among ACT team members, including for the purpose of treatment planning.
- (6) Time spent performing routine services such as cleaning, cooking, shopping or child care designed to provide relief or respite for the primary caregiver.
- (7) No-shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable.
- (8) ACT services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments.
- (9) Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

Community Support Program (CSP)

Definition

Community Support Program (CSP) consist of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, group and individual psycho-education, and skill building for activities of daily living.

CSP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings by a mobile team. Services are focused on skill building with a goal of maximizing independence. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

Rate: \$24.25/qtr. hr

Provider Qualifications/Conditions for Participation

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC).

Other Standards: CSP staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist.

A CSP provider must meet the State of Connecticut certification standards to provide CSP services as defined by the Department of Mental Health and Addiction Services (DMHAS).

Entity Responsible for Verification: DMHAS

Frequency of Verification: At start of services and at recertification.

Unit of Service: 15 Minutes

Covered services

CSP services of at least 15-minutes duration provided to the participant by a direct-care staff member of the CSP team in the participant's home and in other community settings. These services include:

- (1) Rehabilitation assessment and development of the rehabilitation plan.

- (2) Re-evaluation and adjustment of the rehabilitation plan.
- (3) Crisis response services either face-to-face or telephonic.
- (4) Psycho-education services for rehabilitation from psychiatric or substance abuse disorders.
- (5) Clarification of goals and motivational support for pursuing goals related to employment, education, community involvement, and use of natural supports. (Note: documentation shall be maintained in the file of each participant receiving work or education-related services that such services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.)).
- (6) Residential supports, such as motivating the participant to find and lease an apartment, and assistance with tenancy issues and problems.
- (7) Skill building and support for Activities of Daily Living, including:
 - Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving.
 - Other skill development activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the waiver Recovery Plan.
 - Teaching of recovery skills in order to prevent relapse such as symptom recognition, coping with symptoms, emotional management, relaxation skills, self administration and appropriate use of medications, and preparation of illnesses related advance directives.
 - Development of self-advocacy skills for the purpose of accessing natural supports, self-help, and other advocacy resources.
 - Health and wellness education.
- (8) Education, support, and consultation to family members (and significant others) of the participant, provided these activities are directed exclusively toward the rehabilitation treatment of the participant.
- (9) Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator.
- (10) Travel to an appointment with a participant or family member when the CSP provider is also engaged in a qualifying waiver service activity.

- (11) Group treatment, involving not more than four persons receiving care, focusing on any of the activities listed in items #4 through #7 above. (NOTE: Group rates are 30 percent of the individual CSP rate. See applicable rate schedule for details).

Limitations

Coverage of Community Support Program services shall be subject to the following limitations:

- (1) CSP services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.
- (2) CSP services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider.
- (3) A claim for reimbursement may be submitted for the qualifying waiver services activities of only one direct-care member of a CSP team for services to a participant during a specific time period (i.e., billable unit of time).
- (4) With the allowable exception of a transition period to CSP (up to 30 days), individuals receiving residential rehabilitation services paid for by Medicaid in a group home are excluded from CSP.
- (5) The Department shall not pay for:
 - Psychiatric evaluation and treatment, medication management, individual, group and family psychotherapy.
 - Time spent by the provider solely for the purpose of transporting participants.
 - Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.
 - Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history.
 - Programs, services or components of services that are not included in the fee established by the Department.
 - Services or components of services provided solely for social, recreational, educational or vocational purposes.
 - Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

- (1) Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns.

- (2) Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery.
- (3) Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization of services.
- (4) Completion of progress notes or billing documentation.
- (5) Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among CSP team members, including for the purpose of treatment planning.
- (6) Time spent performing routine services such as cleaning, cooking, shopping, or child care designed to provide relief or respite for the family.
- (7) No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable.
- (8) CSP services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments.
- (9) Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

Peer Support

Definition

Peer Support – Is available as a step-down from more intensive waiver services such as Assertive Community Treatment (ACT) or Community Support Program (CSP), when an ACT or CSP level of care is no longer needed. Peer support includes face-to-face interactions that are designed to promote ongoing engagement of persons covered under the waiver in addressing residual problems resulting from psychiatric and substance use disorders, and promoting the individuals strengths and abilities to continue improving socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer support also includes communication and coordination with behavioral health services providers and others in support of the participant.

Rate: \$13.50/qtr.hr

Provider Qualifications/Conditions for Participation

Agency based: A Peer Support specialist shall:

- Be at least 18 yrs old.
- Possess at least a high school diploma or GED.
- Possess a valid Connecticut driver's license.
- Be certified as a Peer Support Specialist in accordance with requirements set by the Department of Mental Health and Addiction Services (DMHAS).
- Meet requirements for ongoing continuing education set by DMHAS.
- Demonstrate ability to support the recovery of others from mental illness and/or substance abuse.

Training requirement: Training programs will address abilities to:

- Follow instructions given by the participant or the participant's conservator.
- Report changes in the participant's condition or needs.
- Maintain confidentiality.
- Meet the participant's needs as delineated in the waiver Recovery Plan.
- Implement cognitive and behavioral strategies.
- Function as a member of an interdisciplinary team.
- Respond to fire and emergency situations.
- Accept supervision in a manner prescribed by the Department or its designated agent.
- Maintain accurate, complete and timely records that meet Medicaid requirements.
- Use crisis intervention and de-escalation techniques.
- Provide services in a respectful, culturally competent manner.
- Use effective Peer Support practices.

Unit of Service: 15 Minutes

Covered services

Peer Support services of at least 15-minutes duration provided face-to-face with the participant in his/her home and in other community settings. These services include:

- (1) Coaching and support related to:
 - Continued use of recovery skills.
 - Involvement in community activities and positive relationships with family and friends.
 - Attention to personal hygiene and appropriated dress.
 - Involvement in vocational, volunteer or educational activities.
 - Follow through on personal obligations and commitments.
 - Self advocacy during self-help, peer support and community meetings.
 - Self advocacy during meetings with providers to facilitate linkage, communication and improved continuity of care.
 - Development of natural supports.
 - Filing complaints and follow-up with proposed resolution as needed, finding resources.

- (2) Assisting with avoidance of:
 - Behaviors that might lead to a psychiatric crisis.
 - Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities).
 - Substance abuse.
 - Overspending.
 - Unnecessary conflict.

- (3) Mentoring and advice to facilitate development of effective decision making and problem solving skills.

- (3) Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator.

- (4) Travel with the participant when the Peer Support provider is also engaged in a qualifying waiver service activity.

Limitations

Coverage of Peer Support services shall be subject to the following limitations:

- (1) Peer Support services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.

- (2) Peer Support services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider.
- (3) Individuals receiving Assertive Community Treatment (ACT) or Community Support Program (CSP), both of which have a peer support component, are excluded from waiver Peer Support services, except during a brief transition phase (not to exceed 30 days) between ACT or CSP and Peer Support.
- (4) A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Peer Support services to a participant during a specific time period (i.e., billable unit of time).
- (5) The department shall not pay for:
 - Time spent by the provider solely for the purpose of transporting participants.
 - Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.
 - Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history.
 - Programs, services or components of services that are not included in the fee established by the department.
 - Services or components of services provided solely for social, recreational, educational or vocational purposes.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

- (1) Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns.
- (2) Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery.
- (3) Telephone contact with the participant.
- (4) Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization of services.
- (5) Completion of progress notes or billing documentation.
- (6) Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning.

- (7) No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable.
- (8) Peer Support services of less than fifteen minutes duration for procedures whose billing codes are defined in 15-minute increments.
- (9) Time spent engaged in activities required by a credentialing or oversight entity such as gathering and submitting care plan or service data or other information.

Recovery Assistant

Definition

Recovery Assistant – A flexible range of supportive assistance provided face-to-face in accordance with a Waiver Recovery Plan that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. Service activities include: performing household tasks, providing instructive assistance, or cuing to prompt the participant to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and participation in social and recreational activities), and; providing supportive companionship. The Recovery Assistant may also provide instruction or cuing to prompt the participant to dress appropriately and perform basic hygiene functions; supportive assistance and supervision of the participant, and; short-term relief in the home for a participant who is unable to care for himself/herself when the primary caregiver is absent or in need of relief.

Rates: Agency based - \$5.50/qtr. Hr.; Individual - \$3.25/qtr. hr

Provider Qualifications/Conditions for Participation (Both Individual and Agency-Based)

A Recovery Assistant shall:

- Be at least 18 yrs old.
- Possess at least a high school diploma or GED.
- Possess a valid Connecticut driver's license.
- Be Bonded for \$10,000, if performing money management for the participant.
- Be registered with the Department of Mental Health and Addiction Services (DMHAS) as having completed an approved Recovery Assistant training program and meet any continuing education and/or training requirements set by DMHAS.

Training requirement: Training programs will address abilities to:

- Follow instructions given by the participant or the participant's conservator.
- Report changes in the participant's condition or needs.
- Maintain confidentiality.
- Meet the participant's needs as delineated in the waiver Recovery Plan.
- Implement cognitive and behavioral strategies.
- Function as a member of an interdisciplinary team.
- Respond to fire and emergency situations.
- Accept supervision in a manner prescribed by the Department or its designated agent.
- Maintain accurate, complete and timely records that meet Medicaid requirements.
- Use crisis intervention and de-escalation techniques.
- Provide services in a respectful, culturally competent manner.

Unit of Service: 15 Minutes

Covered services

Recovery Assistant services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

- (1) Performing the following tasks if the participant (by reason of physical or psychiatric disability) is unable to perform them, or assisting, or cueing the participant to perform them.
- (2) Meal planning and preparation, shopping, housekeeping (e.g., changing linens, washing dishes, vacuuming/dusting, laundry, mending clothing repairs), basic household tasks (e.g., regulating home temperature, storing food appropriately, resolving issues about bill paying).
- (3) Dressing, personal grooming and hygiene (e.g., bathing, dressing, and oral care).
- (4) Appropriate use of emergency medical services.
- (5) Assisting or cueing the participant to perform or become engaged in:
 - Family, social, and recreational activities.
 - Appropriate use of natural community supports (e.g., social clubs, faith-based supports).
 - Appropriate use of routine medical/dental services.
 - Use of medications as prescribed, including self administration of medications.
 - Healthy habits (e.g., healthy diet, exercise, and behaviors designed to alleviate stress).
 - Fulfillment of personal commitments, and adherence to scheduled appointments/meetings (e.g., clinical, vocational, educational, and judicial/court).
- (6) Assisting or cueing the participant to avoid:
 - Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities).
 - Substance abuse.
 - Overspending.
 - Unnecessary conflicts.
- (7) Supportive and problem solving-oriented discussions with the participant.
- (8) Establishing and maintaining a helpful, supportive, companionship relationship with the participant that involves such activities as:
 - Escorting the participant to necessary medical, dental, or personal business appointments.
 - Reading to or for the participant.
 - Engaging in or discussing recreational, hobby, or sport-related activities.

- (9) Other activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence.
- (10) Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator.
- (11) Travel with a participant when the Recovery Assistant is also engaged in a qualifying waiver service activity.

Limitations

Coverage of Recovery Assistant services shall be subject to the following limitations:

- (1) Recovery Assistant services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.
- (2) Recovery Assistant services shall be based on the waiver Recovery Plan.
- (3) A claim for reimbursement may be submitted for the qualifying waiver services activities of only one Recovery Assistant for services to a participant during a specific time period (i.e., billable unit of time).
- (4) Individuals receiving residential rehabilitation services paid for by Medicaid in a group home are excluded from Recovery Assistant services, except during a brief transition phase to a lower level of care (not to exceed 30 days).
- (5) The Department shall not pay for:
 - Time spent by the provider solely for the purpose of transporting participants.
 - Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.
 - Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history.
 - Programs, services or components of services that are not included in the fee established by the Department.
 - Services or components of services provided solely for educational or vocational purposes.
 - Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

- (1) Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
- (2) Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
- (3) Telephone contact with the participant;
- (4) Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization of services;
- (5) Completion of progress notes or billing documentation;
- (6) Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
- (7) No-shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
- (8) Recovery Assistant services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
- (9) Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

Short-Term Supervision and Support

Definition

Short-term supervision and support – Consists of face-to-face mental health and substance abuse services provided to individuals within the home and community. The service involves brief, concentrated interventions to stabilize psychiatric conditions or behavioral and situational problems including substance abuse, prevent escalation of psychiatric symptoms, reduce the risk of harm to self or others, avert loss of housing, and wherever possible to avoid the need for hospitalization or other more restrictive placement. Services and interventions are highly individualized and tailored to the needs and preferences of the participant, with the goal of maximizing independence and supporting recovery.

Rate: \$12.00/qtr. Hr.

Provider Qualifications/Conditions for Participation

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC)

Other Standards: Short-term supervision and support staff shall have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities)

Meet the State of Connecticut certification standards to provide Short-Term Supervision and Support services defined by the Department of Mental Health and Addiction Services

Entity Responsible for Verification: DMHAS

Frequency of Verification: At start of services and at recertification

Agency based: A Short-term Supervision and Support staff member shall:

- Be at least 18 yrs old.
- Possess at least a high school diploma or GED.
- Possess a valid Connecticut driver's license.

Training requirement: Training programs will address abilities to:

- Follow instructions given by the participant or the participant's conservator.
- Report changes in the participant's condition or needs.
- Maintain confidentiality.
- Meet the participant's needs as delineated in the waiver Recovery Plan.
- Implement cognitive and behavioral strategies.
- Function as a member of an interdisciplinary team.
- Respond to fire and emergency situations.
- Accept supervision in a manner prescribed by the Department or its designated agent.
- Maintain accurate, complete and timely records that meet Medicaid requirements.

- Use crisis intervention and de-escalation techniques.
- Provide services in a respectful, culturally competent manner.
- Use effective and evidence-based Short-term Supervision and Support practices.

Unit of Service: 15 Minutes

Covered services

Short-term supervision and support services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

- (1) Observation, evaluation and monitoring in order to reduce the participant's risk of harm to self or others, and to determine whether additional supports are necessary.
- (2) Practical problem-solving advice and assistance designed to address and remediate the antecedent causes of an emerging psychiatric or behavioral crisis.
- (3) Crisis intervention and supportive counseling designed to stabilize functioning, reduce stress, calm the participant and prevent further deterioration.
- (4) Communication with supervisory staff to report the participant's condition and whether any additional assistance is needed.
- (5) Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator.
- (6) Travel with a participant when the Short-term Supervision and Support provider is also engaged in a qualifying waiver service activity.

Limitations

Coverage of Short-term Supervision and Support services shall be subject to the following limitations:

- (1) Short-term Supervision and Support services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.
- (2) Short-term Supervision and Support services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider.
- (3) A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Short-term Supervision and Support services to a participant during a specific time period (i.e., billable unit of time).
- (4) The Department shall not pay for:
 - Time spent by the provider solely for the purpose of transporting participants.

- Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.
- Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history.
- Programs, services or components of services that are not included in the fee established by the Department.
- Services or components of services provided solely for social, recreational, educational or vocational purposes.
- Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

- (1) Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery.
- (2) Telephone contact with the participant.
- (3) Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization.
- (4) Completion of progress notes or billing documentation.
- (5) Individual or group supervision, routine case reviews and rounds, ad-hoc consultation with supervisors and discussion or consultation among CSP team members, including for the purpose of treatment planning.
- (6) No-shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable.
- (7) Short-term supervision and support services of less than fifteen minutes duration for procedures whose billing codes are defined in 15-minute increments.
- (8) Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan or service data or other information.

Supported Employment

Definition

Supported Employment Services – Consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings; particularly work sites where persons with disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptation, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Rate: \$15.75/qtr. Hr.

Provider Qualifications/Conditions for Participation

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC).

Other Standards: Requirements set by DMHAS.

Entity Responsible for Verification: DMHAS

Frequency of Verification: At start of services and at recertification.

Agency based: A Supported Employment staff member shall:

- Be at least 18 yrs old.
- Possess at least a high school diploma or GED.
- Possess a valid Connecticut driver's license.

Training requirement: Training programs will address abilities to:

- Follow instructions given by the participant or the participant's conservator.
- Report changes in the participant's condition or needs.
- Maintain confidentiality.
- Meet the participant's needs as delineated in the waiver Recovery Plan.
- Implement cognitive and behavioral strategies.
- Function as a member of an interdisciplinary team.
- Respond to fire and emergency situations.
- Accept supervision in a manner prescribed by the Department or its designated agent.
- Maintain accurate, complete and timely records that meet Medicaid requirements.
- Use crisis intervention and de-escalation techniques.

- Provide services in a respectful, culturally competent manner.
- Use effective and evidence-based Supported Employment practices.

Unit of Service: 15 Minutes

Covered services

Supported Employment services of at least 15-minutes duration provided to the participant face-to-face or telephonically in the participant's home, employment location, or other community settings. These services include:

- (1) Training, skill building and support to assist the participant with managing his/her symptoms or other manifestations of disability in the workplace or job interview.
- (2) Assessment of the participant's:
 - Individualized career development goals and employment ideas/preferences.
 - Work related skills and vocational functioning.
- (3) Assistance in developing and periodically evaluating the individualized employment services component of the participant's waiver Recovery Plan;
- (4) Support and guidance through the process of obtaining and maintaining employment, including:
 - Teaching strategies to explore career development, write a resume, conduct job networking, pursue job leads, complete job applications, obtain interviews, and succeed in obtaining and maintaining employment.
 - Training and skill building regarding proper work habits, and appropriate interactions with coworkers and the public.
 - Advocating for the participant with potential and current employers.
 - Assisting with and reinforcing work-related problem solving skills.
- (5) Reinforcement of recovery skills designed to promote job retention and success in the workplace, including:
 - Healthy habits (e.g., healthy diet, exercise, medication management and behaviors designed to alleviate stress).
 - Fulfillment of personal and work-related commitments (e.g., adherence to the work schedule, avoidance of unnecessary tardiness and absences from work).
 - Identification and use of natural supports.
- (6) Assistance to support self-employment, including:
 - Aiding the participant to identify potential business opportunities.
 - Assisting in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business.
 - Identification of the supports that are necessary in order for the participant to operate the business.
 - Ongoing assistance, counseling and guidance once the business has been launched.

- (7) Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator.
- (8) Travel with a participant when the Supported Employment provider is also engaged in a qualifying waiver service activity.

Limitations

Coverage of Supported Employment services shall be subject to the following limitations:

- (1) Supported Employment services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.
- (2) Supported Employment services shall be based on the waiver Recovery Plan.
- (3) Documentation shall be maintained in the file of each participant receiving Supported Employment that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- (4) A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Supported Employment services to a participant during a specific time period (i.e., billable unit of time).
- (5) The Department shall not pay for:
 - Costs associated with starting up or operating a business.
 - Sheltered work or any other similar types of vocational services furnished in specialized facilities.
 - Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
 - Payments passed through to participants in supported employment programs.
 - Training not directly related to an individual's supported employment program.
 - Programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms.
 - Time spent by the provider solely for the purpose of transporting participants.
 - Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.
 - Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history.
 - Programs, services or components of services that are not included in the fee established by the Department.
 - Services or components of services provided solely for social, recreational, educational or vocational purposes.
 - Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

- (1) Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns.
- (2) Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery.
- (3) Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization of services.
- (4) Completion of progress notes or billing documentation.
- (5) Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning.
- (6) No-shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable.
- (7) Supportive Employment services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments.
- (8) Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.
- (9) Costs associated with room and board for participants.

Transitional Case Management

Definition

Traditional Case Management – Services provided to persons residing in institutional settings prior to their transition to the waiver to prepare them for discharge, or during the adjustment period immediately following discharge from an institution to stabilize them in a community setting, and to assist them with other aspects of the transition to community life by helping them gain access to needed waiver and other state plan services, as well as medical, social, housing, educational and other services and supports, regardless of the funding source for the services or supports to which access is gained. The State shall claim the cost of case management services provided to institutionalized persons prior to their transition to the waiver for a period not to exceed 60 days.

Rate: \$15.75/qtr. Hr Limited to 60 days; 200 units

Provider Qualifications/Conditions for Participation

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC)

Other Standards: Transitional Case Management staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist.

Meet any other certification standards defined by the Department of Mental Health and Addiction Services.

Entity Responsible for Verification: DMHAS

Frequency of Verification: At start of services and at recertification.

Agency based: A Transitional Case Manager shall:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED; and
- Possess a valid Connecticut driver's license;

Training requirement: Training programs will address abilities to:

- Follow instructions given by the participant or the participant's conservator.
- Report changes in the participant's condition or needs.
- Maintain confidentiality.
- Meet the participant's needs as delineated in the waiver Recovery Plan.
- Implement cognitive and behavioral strategies.
- Function as a member of an interdisciplinary team.

- Respond to fire and emergency situations.
- Accept supervision in a manner prescribed by the Department or its designated agent.
- Maintain accurate, complete and timely records that meet Medicaid requirements.
- Use crisis intervention and de-escalation techniques.
- Provide services in a respectful, culturally competent manner.
- Use effective Transitional Case Management practices.

Unit of Service: 15 Minutes

Covered Services

Transitional case management services of at least 15-minutes duration include:

- (1) Referral and related activities to help an participant obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
- (2) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the waiver Recovery Plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as:
 - Whether services are being furnished in accordance with an individual's Recovery Plan.
 - Whether the services in the Recovery Plan are adequate.
 - Whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the Recovery Plan and service arrangements with providers.
- (3) Face-to-face, telephonic and other contacts with the participant to assist preparation for discharge from an institutional setting and adjustment to community life immediately following discharge.
- (4) Contacts with landlords and vendors designed to locate and secure suitable housing, and make preparations necessary for the arrival of the participant, including such items as assuring:
 - A lease is signed and a security deposit is made, if needed.
 - Utilities or service access is obtained (telephone, electricity, heating and water).
 - Essential home/apartment furnishings are obtained and in place.
 - Other basic essentials are obtained and are in place, including window coverings, food preparation items, bed and bath linens, and personal care items.

- (5) Introducing the participant to other professionals or paraprofessionals involved in the waiver Recovery Plan.
- (6) Providing information, education and training for the participant regarding:
 - Household budget, living costs, and lease and utility arrangements.
 - Security features and the safe operation of appliances in the home.
 - Availability and how to access Community resources.
- (7) Assisting with or making arrangement for setting up the new home, including procuring, moving, and arranging finishing, appliances, and other household items.
- (8) Supervised visits with the participant to the participant's home, or to locate a suitable home during the transition from an institutional setting.
- (9) Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator.
- (10) Travel with a participant or family member(s) when the Transitional Case Manager is also engaged in a qualifying waiver service activity.

Limitations

Coverage of Transitional Case Management services shall be subject to the following limitations:

- (1) Transitional Case Management services are limited to a period of 180 days and two hundred (200) ¼ hour service units. However, additional limitations on the volume and duration of these services may be specified in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.
- (2) Transitional Case Management services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider.
- (3) A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Transitional Case Management services to a participant during a specific time period (i.e., billable unit of time).
- (4) The Department shall not pay for:
 - Transitional Case Management while the participant is receiving Medicaid funded Targeted Case Management services.
 - Time spent by the provider solely for the purpose of transporting participants.
 - Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.
 - Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history.
 - Programs, services or components of services that are not included in the fee established by the Department.

- Services or components of services provided solely for social, recreational, educational or vocational purposes.
 - Costs associated with room and board for participants.
- (5) With the allowable exception of a transition period (up to 30 days), individuals receiving residential rehabilitation services paid for by Medicaid in a group home are excluded from Transitional Case Management.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

- (1) Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
- (2) Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
- (3) Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization;
- (4) Completion of progress notes or billing documentation;
- (5) Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
- (6) No-shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
- (7) Transitional Case Management services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
- (8) Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan or service data or other information.

Additional Services Include

Home Accessibility Modifications limited to \$10,000 annually

Specialized Medical Equipment limited to \$10,000 annually

Non-Medical Transportation (agency based) \$1,000 max per year

Non-Medical Transportation (individual) \$1,000 max per year

Chronic Care Aging Disability Qualified Service Package for Persons in Elderly and Physical Disability Target Groups

The following services are approved under the Home Care Program for Elders Waiver – 0140.90.R1.04 and will be offered under the MFP demonstration of the new Chronic Care Aging Disability waiver.

Case Management:

Rate Agency: \$4.75/day

Service Definition: Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and to other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendix A.

Homemaker

Rate: Agency or individual hired by participant \$4.00/qtr hr

Service Definition: Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

In addition, laundry services may be provided by professional cleaning companies.

Respite Care

Rate: Agency or individual hired by the participant \$167 per day limited to 20 units per year

Service Definition: Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Respite will be provided in the following locations:

Individual's home or place of residences, foster home, Medicaid certified NF, Other community care residential facility approved by the State that its not a private residence; specifically, Licensed Home for the Aged, Adult Family Living Provider.

Adult Day Health

Rate: Agency - \$65.00

Service Definition: Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day). Physical, occupational and speech therapies indicated in the individual’s plan of care will be furnished as component parts of this service.

Transportation between the individuals’ place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

Transportation

Rate: Agency - \$20.00/trip limited to 25 trips per year; Individual- .42/mi (Max \$500 per year)

Service Definition: Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42.CFR 440.170(a), and shall not replace them.

Social and Community Service transportation is provided to fund access to appropriate social or recreational facilities. Transportation services under the waiver shall be offered in accordance with the individual’s plan of care. Wherever possible, family neighbors, friends or community agencies which can provide this service without charge will be utilized.

Chore services

Rate: Agency \$4.00 Individual \$2.59

Service Definition: Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual nor anyone else in the household, is capable of performing or financially providing for them and where no other relative, caregiver, landlord community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Personal Emergency Response Systems (PERS)

Rate: Agency or Individual \$57.20 per month

Service Definition: Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

Adult Residential Care

Rate: Agency or individual \$37.27 per day

Service Definition: Adult foster care; (Adult family living) Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State Law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed 4. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to an inherent in the providing of adult foster care services.

Assisted Living

Service Definition: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include: Home health care, medication administration, transportation specified in the plan of care, and periodic nursing evaluations.

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

Assisted living services shall be limited to services areas covered by Pilot projects established by Public Act 97-2 of the June 18th Special Session. Special Sessions Public Act 98-239 and Public Act 02-7. All other services shall be available State-wide. Separate payments will not be made for homemaker, attendant care, personal care, companion, or chore services. Since the activities included under these services are integral to and inherent in the provision of Assisted Living.

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family.

Home delivered meals

Rate: 2 meals \$8.57

Service Definition: Home Delivered Meals are "Meals on Wheels" include the preparation and delivery one (1) or (2) meals for persons who are unable to prepare or obtain nourishing meals on their own. Payment under the home care program is not available for more than 2 meals a day.

Mental Health Counseling

Rate: Agency or individual - \$53.19

Service Definition: Mental Health Counseling Services are professional counseling service provided to help resolve or enable the eligible individual to cope with individual, family, and/or environmentally related problems and conditions. Counseling focuses on issues such as problems in maintaining a home in the community, relocation within the community, dealing with a long term disability, substance abuse, and family relationships.

The following services will be offered under the Chronic Care waiver and are authorized under either DDS or ABI 1915(c) waivers in the State of Connecticut

Independent Support Broker (Family and Individual Consultation and Support under DDS waiver)

Rate: Billed in qtr units; \$50.01/hr

Service Definition: Support and Consultation provided to individuals and/or their families to assist them in directing their own plan of individual support. This service is limited to those who direct their own supports. The services included are:

- Assistance with developing a natural community support network.
- Assistance with managing the Individual Budget.

- Support with and training on how to hire, manage and train staff.
- Accessing community activities and services, including helping the individual and family with day to day.
- Coordination of needed services.
- Assistance with negotiating rates and reimbursements.
- Developing an emergency back up plan.
- Self advocacy training and support.

Participant Directed Service

Qualifications:

Prior to Employment:

- 21 yrs of age
- Criminal background check
- Registry check
- Demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the Individual Plan.
- Five years experience in working with people with physical disabilities or who are elderly involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care.
- One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with physical disabilities or who are elderly in the areas of behavior, education or rehabilitation.

Substitutions Allowed: College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four years.

- Demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- Demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services
- Demonstrate understanding of individual budgets and DSS fiscal management policies

Personal Care

Rate: Individual Max 18 hrs/day (72 units) \$3.45/qtr. Hr. Agency with choice - \$130.00 per day

Service Definition: One or more persons assisting a person with a disability with tasks that the disabled individual would typically do for him/herself in the absence of a disability. Such tasks can be related to personal needs as well as community and work-related needs, and assistance may be performed at home, in the community or at work. Such services may include physical or verbal assistance to the consumer in accomplishing any Activity of Daily Living (ADL), Instrumental Activities of Daily Living (IADL). Personal Assistance Services also includes alternative and/or cost-effective methods of obtaining assistance that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance, e.g. a microwave oven, sending out laundry, etc. ADLs include bathing, dressing, toileting, transferring, feeding. IADLs include meal preparation, medication administration.

Limits on the amount duration or scope:

- (1) The department assigns a base number of hours to each classification group.
- (2) The department will deduct from the base hours to account for the participant's informal supports.
- (3) The assessment tool determines the adjustment for informal supports by determining the amount of assistance available to meet the participant's needs, assigns it a numeric percentage, and reduces the base hours assigned to the classification group by the numeric percentage.

Private Household Employee

Qualifications:

A personal care provider shall:

- Be at least 18 years of age.
- Have experience doing personal care.
- Be able to follow written or verbal instructions given by the consumer or the consumer's conservator.
- Be physically able to perform the services required.
- Follow instructions given by the consumer or the consumer's conservator.
- Receive instruction/training from consumer or their designee concerning all personal care services delineated in the service plan.
- Be able to handle emergencies.
- Be able to function as a member of an interdisciplinary team.

Environmental Accessibility Adaptations:**Rate: Maximum benefit over 5 year period not to exceed \$10,000.**

Service Definition: Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Vehicle Modifications**Rate: Maximum benefit over 5 year period \$10,350**

Service Definition: Alterations made to a vehicle, which is the individual's primary means of transportation when such modifications are necessary to improve the waiver participant's independence and inclusion in the community and to avoid institutionalization. The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

Note: Vehicle Modifications Services do not include the purchase or lease, regular maintenance or upkeep of the vehicle.

Qualifications:

Private contractors/business that must be approved by the State of Connecticut Bureau of Rehabilitation Services. They must possess a DMV dealer's and/or repairer's license.

Pre-Vocational Service**Rate: Max Service Amount- 40 hrs/week; \$36.35/hour Individual or Agency**

Service Definition: Pre-vocational services are designed to prepare an individual for paid or unpaid employment, when the person is not expected to be able to join the workforce of participate in the transitional work program within one year (excluding supported employment programs)

Pre-vocational services do not include skill-building or job tasks for specific employment goals, but instead focus on teaching the concepts of compliance, attendance, task completion, problem-solving and safety, with the goal of enhancing attention span and motor skills. Pre-vocational services may include participant who perform volunteer work with pre-vocational supports.

When waiver participants are paid for pre-vocational services, they are paid at less than 50% of the minimum wage.

Pre-vocational services may not otherwise be available under a program funded under the Rehabilitation Act of 1073 as amended. Pre-vocational services are not provided under the waiver when participants are eligible for such services through special education.

Provider qualifications:

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) Employment Services or, any provider that meets the State of Connecticut Standard to provide vocational services for the Bureau of Rehabilitation Services.

Transitional Services

Rate: \$600 per transitional occurrence.

Service Definition: Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Department of Developmental Disabilities
Qualified MFP Services
Comprehensive and Individual and Family Support Waivers

Waiver Services
Codes Units and Rates

Service	Procedure Codes	Units/ Smallest unit increment	Vendor Rate
Residential Habilitation (SL)	T 2016	Contract	DMR Contract
Supported Living - Comp Waiver	97535	Hour / 15 minutes	32.20/hour
Individual Support Habilitation (IS) – IFS Waiver	97535	Hour / 15 minutes	32.20/hour
Personal Support	T 1019	Hour / 15 minutes	26.82/hour
Adult Companion	S 5135	Hour / 15 minutes	16.94/hour
Supported Employment Individual	T 2019	Hour / 15 minutes	58.11/hour
Supported Employment Group	T 2019	Hour / 15 minutes	10.90/hour
Supported Employment Group w/B	T2019B	Hour / 15 minutes	11.41/hour
Group Day – Day Support Option (DSO)	T 2021	Hour / 15 minutes	15.88/hour
Group Day – Shelter Workshop (SHE)	T2021	Hour / 15 minutes	7.72/hour
Group Day – SHE w/B	T2021B	Hour / 15 minutes	8.07/hour
Individualized Day	97537	Hour / 15 minutes	Negotiated (Cap of 32.20/hour)
Respite Individual (in home) Daily	S 5151	1 day	299.07/day
Respite Individual (in home) Hourly	S 5150	Hour / 15 minutes	24.92/hour
Respite Individual (out of home) Daily	S 5151	1 day	326.18/day
Respite Individual (out of home) Hourly	S 5150	Hour / 15 minutes	26.05/hour
Respite Group (in/ out of home) Daily	S 5151	1 day	126.80/day
Respite Group (in/ out of home) Hourly	S 5150	Hour / 15 minutes	9.44/hour
Personal Emergency Response System (Install)	1222 Z	One Time	33.98/install
Personal Emergency Response System (2 way)	1223 Z	1 month	56.63/month
Transportation	S 0215	1 mile	.43/mile
Transportation – one way trip		Trip	
Specialized Medical Equipment	T 2029	1 Unit	
Consultative Services			
Behavioral	H 2019	Hour / 15 minutes	71.02/hour
Counseling	S 9482	Hour / 15 minutes	71.02/hour
Nutrition	S 9470	Hour / 15 minutes	71.02/hour
Interpreter Services	T 1013	Hour / 15 minutes	54.63/hour
Family and Individual Consultation and Support (FICS)	T 2040	Hour / 15 minutes	51.50/hour
Intensive Staffing Support (Group Day & Respite Only)	Group Day Procedure Code + "Sup"	Hour / 15 minutes	11.41/hour
Assisted Living Com Waiver only			
Level 1	1430Z	Per Diem/Daily	23.78/day
Level 2	1431Z	Per Diem/Daily	39.17/day
Level 3	1432Z	Per Diem/Daily	55.16/day
Level 4	1433Z	Per Diem/Daily	71.02/day
Core Services	1434Z	Per Diem/Daily	4.37/day
Individual Directed Goods and Services-Comp Waiver only	T2025	Manual entry/unit	Negotiated

Revised
2/22/08

Overview

The following pages contain procedure code lists to be used when submitting claims for the waiver programs and special services referenced in this chapter. Providers should review Chapter 7, Medical Services Policy, as applicable to the waiver program or special services for complete information on reimbursement and payment limitations.

Acquired Brain Injury Services Procedure Code List

Proc. Code	Description of Service	Max Service Am't	Rate
1530P	Case-Management	12 hrs/day	\$ 17.34/hr.
1532P	Chore (Agency)	8 hrs/day	\$ 3.96/qtr. hr.
1532P	Chore (Private)	8 hrs/day	\$ 2.51/qtr. hr.
1534P	Community Living Support Services (CLSS)	\$126.00/day	\$ 63.00/half day
1536P	Companion Services (Agency)	18hrs/day (72 qtr. hr. units)	\$ 3.52/qtr. hr.
1536P	Companion Services (Private)	18hrs/day (72 qtr. hr. units)	\$ 2.99/qtr. hr.
1538P	Environmental Accessibility Adaptations	\$10,000 units/year	\$ 10,000/year
1542P	Homemaker Services (Agency)	8 hrs/day (32 units)	\$ 3.96/qtr. hr.
1542P	Homemaker Services (Private)	8 hrs/day (32 units)	\$ 2.51/qtr. hr.
1546P	Independent Living Skill Development (Indiv.)	12 hrs/day	\$ 35.00/hr/indiv
1548P	Cognitive/Behavioral Programs	4 hrs/day	\$ 80.00/hr
1550P	Home-Delivered Meals (single)	Single only/day	\$ 4.65
1551P	Home-Delivered Meals (double meal)	Double only/day	\$ 8.50
1554P	Personal Care Assistant (private only)	18 hrs/day (72 units)	\$ 3.35/qtr. hr.
1556P	Personal Emergency Response System (PERS)	One-time install	\$ 33.98
1557P	Personal Emergency Response System (monthly service)	\$56.63 2-way/mo	\$ 28.32 1-way/mo
1560P	Pre-Vocational Services	40 hrs/week	\$ 35.25/hr.
1562P	Respite Care	24 hrs/day	\$ 11.25/hr.
1564P	Specialized Medical Equipment & Supplies	\$10,000/year	\$ 10,000/year
H2036	Substance Abuse Program (daily)	56 days/yr	\$ 50.00/day
H2035	Substance Abuse Program (hourly)	4 hrs/day	\$ 42.45/hr.
1572P	Supported Employment	40 hrs/week	\$ 35.29/hr.

Proc. Code	Description of Service	Max Service Am't	Rate
T1013	Sign Language or Oral Interpretive Services	Per 15 minutes	Variable rate
1574P	Transportation (Public)	4 trips/day	\$ 24.66/ 1-way trip
1575P	Transportation (Mileage--Private)	999 miles/day	\$.25/mile
1578P	Vehicle Modification	\$10,000/year	\$ 10,000/year
1580P	Transitional Living Services	183 days/yr (1x only)	\$ 197.00/day

Appendix G: Institutional Facilities

**DMR PUBLIC
ICFs/MR**

JULY 2007

ICFs/MR	ICF/MR Capacity (# "Certified beds")	# ICFs/ MR	Total ICF/MR Capacity
DMR		51	796
WEST REGION		41	686
Ella Grasso Center 300 Armory Road Stratford, CT 06497		2	47
EGC Building 1	16		
EGC Building 2	31		
Lower Fairfield Center 146 Silvermine Ave. Norwalk, Ct. 06850		3	72
LFC Building 1	24		
LFC Building 2	24		
LFC Building 3	24		
Torrington Center 195 Alvord Park Rd. Torrington, Ct. 06790		2	41
NWC Building 1	24		
NWC Building 2	17		
Southbury Training School PO Box 872 Southbury, CT 06488		34	526
STS Cottage 1	9		
STS Cottage 2	14		
STS Cottage 4	13		
STS Cottage 5	14		
STS Cottage 7	7		
STS Cottage 8	11		
STS Cottage 9/19 Hartford Hill	16 (Cottage 9-11, 19 Hartford Hill-5)		
STS Cottage 11	14		
STS Cottage 14	16		
STS Cottage 15	20		
STS Cottage 16	18		
STS Cottage 17	14		
STS Cottage 18/3 Yankee Drive	23 (Cottage 18-14, 3 Yankee Drive-9)		
STS Cottage 20	13		
STS Cottage 26	14		
STS Cottage 28	15		
STS Cottage 29	15		
STS Cottage 30	23		
STS Cottage 31	21		
STS Cottage 32	14		
STS Cottage 33	26		

ICFs/MR	ICF/MR CAPACITY (# "Certified beds")	# ICFs/MR	Total ICF/MR Capacity	
STS Cottage 34	14			
STS Cottage 36	14			
STS Cottage 37	14			
STS Cottage 40	18			
STS Cottage 41-L	18			
STS Cottage 41-U	4			
STS Cottage 42	15			
STS Farm 1/Purchase Brook House	22 (Farm 1-20, Purchase Brook House-2)			
STS Personnel Village	34 (PV3-4, PV4-4, PV6-3, PV7-3, PV13-3, PV15-3, PV19-3, PV20-3, PV22-5, PV28-3)			
STS 12 Constitution Hill	12			
STS 21 Colony Court	9			
STS 22 Colony Court	15			
STS 27 Colony Court Circle	7			
NORTH REGION		5		66
Newington Center 71 Mountain Road Newington, Ct. 06111		5		66
NR 67/69/73 Mountain Road	27 (67 Mountain Road-5, 69 Mountain Road-10, 73 Mountain Road-12)			
NR 77/79 Mountain Road	12 (77 Mountain Road-7, 79 Mountain Road-5)			
NR 81/83 Mountain Road	13 (81 Mountain Road-6, 83 Mountain Road-7)			
NR 85 Mountain Road	10			
NR 87 Mountain Road	4			
ICFs/MR	Contact People	ICF/MR CAPACITY (# "Certified beds")	# ICFs/MR	Total ICF/MR Capacity
SOUTH REGION			5	44
Meriden Center 35 Undercliff Road Meriden, Ct. 06450	Carl Richectelle, Residential Manager		3	26
SR Cottage 11		4		
Cottages 9/12 & Transition Unit		9 (Cottage 9-1, Cottage 12-4, Transition Unit-4)		

SR Units A/B & C		13 (Unit A-6, Unit B-6, Unit C-1)		
Mystic Education Center 240 Oral School Road Mystic, CT 06355	Beverly Tulisano, Residential Manager		2	18
SR Durant/Riverview Unit		13 (Durant-6, Riverview-7)		
SR Rainbow House		5		

Provider Name
BRIDGEPORT HOSPITAL INC
BRISTOL HOSPITAL
DANBURY HOSPITAL
DAY KIMBALL HOSPITAL
GREENWICH HOSPITAL
GRIFFIN HOSPITAL
HARTFORD HOSPITAL
HOSPITAL OF SAINT RAPHAEL
JOHN DEMPSEY HOSPITAL
JOHNSON MEMORIAL HOSPITAL
LAWRENCE AND MEMORIAL HOSPITAL
MANCHESTER MEMORIAL HOSPITAL
MIDDLESEX HOSPITAL
MIDSTATE MEDICAL CENTER
NORWALK HOSPITAL ASSOCIATION
ST FRANCIS HOSPITAL MEDICAL CENTER
ST MARYS HOSPITAL
ST VINCENTS MEDICAL CENTER
STAMFORD HOSPITAL
THE CHARLOTTE HUNGERFORD HOSPITAL
THE HOSPITAL OF CENTRAL CONNECTICUT
THE WILLIAM BACKUS HOSPITAL
WATERBURY HOSPITAL
YALE NEW HAVEN HOSPITAL
BETH ISRAEL DEACONESS
BRATTLEBORO RETREAT
CUMBERLAND HOSPITAL
ELMHURST HOSPITAL
EMMA PENDELTON BRADLEY
FORSYTH MEMORIAL

FOUR WINDS
HAMPSTEAD HOSPITAL
KENT COUNTY MEMORIAL HOSPITAL
KIDSPEACE CHILDREN'S HOSPITAL
MONTEFIORE MEDICAL CENTER
MOUNT SINAI
NEW YORK & PRESBYTERIAN
NEW YORK & PRESBYTERIAN
NYU HOSPITAL
PUTNAM HOSPITAL CENTER
STONEY LODGE
UMASS MEMORIAL
HALL-BROOKE BEHAVIORAL HLTH SVCS
NATCHAUG HOSPITAL
CEDARCREST
CT MENTAL HEALTH
CT VALLEY HOSPITAL
RIVERVIEW
SOUTHWEST CENTER

Chronic Care Hospital
Hospital for Special Care

	Facility	Town	Bed Capacity		
			CCH	RHNS	Total
1	Aaron Manor Nursing and Rehab. Center	Chester	60	0	60
2	Abbott Terrace Health Center	Waterbury	205	0	205
3	Alexandria Manor	Bloomfield	120	0	120
4	Alzheimer's Resources Ctr. of CT, Inc.	Plantsville	120	0	120
5	Andrew House Health Care	New Britain	90	0	90
6	Ashlar of Newtown	Newtown	154	0	154
7	Astoria Park	Bridgeport	135	0	135
8	Avery Nursing Home	Hartford	130	69	199
9	Avon Health Center	Avon	120	0	120
10	Bayview Health Care Center	Waterford	127	0	127
11	Beacon Brook Health Center	Naugatuck	126	0	126
12	Beechwood	New London	60	0	60
13	Bel-Air Manor	Newington	71	0	71
14	Bethel Health Care/The Cascades (RCH)	Bethel	161	0	161
15	Bickford Health Care Center	Windsor Locks	48	0	48
16	Bidwell Care Center, LLC	Manchester	156	0	156
17	Birmingham Health Center	Derby	120	0	120
18	Bishop Wicke Health & Rehab. Ctr.	Shelton	120	0	120
19	Blair Manor	Enfield	98	0	98
20	Bloomfield Health Care Center, LLC	Bloomfield	120	0	120
21	Bradley Home & Pavilion	Meriden	30	0	30
22	Branford Hills	Branford	190	0	190
23	Bride Brook Health & Rehab. Center	Niantic	130	0	130
24	Bridgeport Health Care Center Inc.	Bridgeport	300	0	300
25	Bridgeport Manor	Bridgeport	240	0	240
26	Brightview of Avon	Avon	60	0	60
27	Brittany Farms Health Center	New Britain	282	0	282
28	Brook Hollow Health Care Center	Wallingford	180	0	180
29	Caleb Hitchcock Health Center	Bloomfield	60	0	60
30	Cambridge Manor	Fairfield	160	0	160
31	Camelot Nursing & Rehabilitation Ctr.	New London	66	0	66
32	Candlewood Valley Health & Rehab. Center	New Milford	147	0	147
33	Carolton Chronic and Conv. Hospital	Fairfield	229	0	229
34	Cedar Lane Rehab. & Hlth Care Ctr.	Waterbury	180	0	180
35	Chelsea Place Care Center	Hartford	234	0	234
36	Cherry Brook Health Care Center	Collinsville	100	0	100
37	Cheshire House Health Care Fac & Re	Waterbury	60	0	60
38	Chestelm Health Care	Moodus	76	0	76
39	Chesterfields Health Care Center	Chester	60	0	60
40	Chestnut Point Care Center, LLC	East Windsor	56	4	60
41	Clintonville Manor, Inc.	North Haven	0	120	120
42	Cobalt Lodge Health Care & Rehab. Center	Cobalt	60	0	60
43	Coccoma Memorial Health Center	Meriden	100	0	100
44	Connecticut Baptist Homes	Meriden	30	30	60

45	Connecticut Health of Southport	Fairfield	120	0	120
46	Cook Willow Convalescent Hosp. Inc.	Plymouth	60	0	60
47	Countryside Manor	Bristol	90	0	90
48	Courtland Gardens Health Care Center	Stamford	180	0	180
49	Crescent Manor	Waterbury	115	0	115
50	Crest field Rehab Center & Fenwood Manor	Manchester	95	60	155
51	CT Health of Greenwich	Greenwich	75	0	75
52	Curtis Home/St. Elizabeth Center	Meriden	60	0	60
53	Danbury Health Care Center	Danbury	180	0	180
54	Douglas Manor	Windham	90	0	90
55	Elim Park Baptist Home	Cheshire	90	0	90
56	Ellis Manor	Hartford	105	0	105
57	Elm Hill Nursing Center	Rocky Hill	120	0	120
58	Evergreen Health Care Center	Stafford Springs	150	0	150
59	Fairview, Inc.	Groton	120	0	120
60	Farmington Care Center	Farmington	120	0	120
61	Filosa, For Nursing and Rehab.	Danbury	64	0	64
62	Fountainview Care Center	Waterford	120	0	120
63	Fowler Nursing Center	Guilford	90	0	90
64	Fox Hill Center	Rockville	150	0	150
65	Frances Warde Towers	West Hartford	256	0	256
66	Gardner Heights Health Care Center, Inc.	Shelton	124	30	154
67	Geer Nursing and Rehab. Center	Canaan	120	0	120
68	Gladeview Health Care Center	Old Saybrook	132	0	132
69	Glastonbury Health Care Center	Glastonbury	105	0	105
70	Glendale Center	Naugatuck	120	0	120
71	Golden Hill Health Care Center	Milford	120	0	120
72	Greentree Manor Nursing & Rehab. Center	Waterford	90	0	90
73	Greenwich Woods Health Care Center	Greenwich	217	0	217
74	Groton Regency Center	Groton	162	0	162
75	Grove Manor Nursing Home, Inc.	Waterbury	60	0	60
76	Hamden Health Care Center	Hamden	153	0	153
77	Hancock Hall	Danbury	45	47	92
78	Harbor Hill Care Center, Inc.	Middletown	150	0	150
79	Harbor View Manor	West Haven	89	1	90
80	Harborside Healthcare-Arden House Rehab & Nursing Center	Hamden	360	0	360
81	Harborside Healthcare-Glen Hill Rehab & Nursing Ctr.	Danbury	100	0	100
82	Harborside Healthcare-Governor's House Rehab & Nursing Ctr.	Simsbury	73	0	73
83	Harborside Healthcare-Madison House Rehab & Nursing Center	Madison	90	0	90
84	Harborside Healthcare-The Reservoir Rehab & Nursing Center	West Hartford	75	0	75
85	Harborside Healthcare-Willows Rehab & Nursing Ctr.	Woodbridge	90	0	90
86	Harrington Court	Colchester	130	0	130
87	Haven Health Center of Cromwell	Cromwell	175	5	180
88	Haven Health Center of Danielson	Danielson	190	0	190
89	Haven Health Center of East Hartford	East Hartford	180	0	180

90	Haven Health Center of Farmington	Farmington	140	0	140
91	Haven Health Center of Jewett City	Griswold	90	0	90
92	Haven Health Center of New Haven	New Haven	120	0	120
93	Haven Health Center of Norwich	Norwich	119	0	119
94	Haven Health Center of Rocky Hill	Rocky Hill	120	0	120
95	Haven Health Center of South Windsor	South Windsor	120	0	120
96	Haven Health Center of Torrington	Torrington	126	0	126
97	Haven Health Center of Waterbury	Waterbury	90	0	90
98	Haven Health Center of Waterford	Waterford	90	0	90
99	Haven Health Center of West Hartford	West Hartford	130	0	130
100	Haven Health Center of Windham	Willimantic	124	0	124
101	Haven Health Center-Soundview	West Haven	102	0	102
102	Hebrew Home and Hospital, Inc.(includes 45 CDH)	West Hartford	289	45	334
103	Hewitt Health & Rehabilitation Center, Inc.	Shelton	206	0	206
104	Highlands Health Care Center	Cheshire	120	0	120
105	Highview Health Care Center	Middletown	95	0	95
106	Hilltop Health Center	Ansonia	90	0	90
107	Holy Spirit Health Care Center, Inc	Putnam	22	0	22
108	Honey Hill Care Center	Norwalk	150	0	150
109	Hughes Health and Rehabilitation, Inc.	West Hartford	180	0	180
110	Ingraham Manor	Bristol	128	0	128
111	Jefferson House	Newington	72	32	104
112	Jerome Home, The	New Britain	74	20	94
113	Jewish Home For the Aged	New Haven	226	0	226
114	Jewish Home For the Elderly of Fairfield.	Fairfield	359	1	360
115	Kent, LTD, The	Kent	90	0	90
116	Kettle Brook Care Center, LLC	East Windsor	166	0	166
117	Kimberly Hall North	Windsor	150	0	150
118	Kimberly Hall South Center	Windsor	180	0	180
119	Laurel Hill Healthcare	Winsted	75	0	75
120	Laurel Ridge Health Care Center	Ridgefield	126	0	126
121	Laurel Woods, Inc	East Haven	120	0	120
122	Ledgecrest Health Care Center, Inc	Kensington	60	0	60
	Leeway	New Haven			
123	Liberty Specialty Care Center	Colchester	60	0	60
124	Litchfield Woods Health Care Ctr.	Torrington	130	30	160
125	Long Ridge of Stamford	Stamford	120	0	120
126	Lord Chamberlain Manor	Stratford	60	0	60
127	Lord Chamberlain Nursing & Rehabilitation Ctr.	Stratford	190	0	190
128	Lourdes Health Care Center, Inc.	Wilton	40	0	40
129	Ludlowe Center	Fairfield	144	0	144
130	Lutheran Home of Southbury, Inc.	Southbury	120	0	120
131	Maefair Health Care Center, Inc	Trumbull	134	0	134
132	Manchester Manor, Inc.	Manchester	126	0	126
133	Mansfield Center for Nursing & Rehab	Storrs	98	0	98
134	Maple View Manor	Rocky Hill	120	0	120
135	Marathon Healthcare Center of New Haven	New Haven	150	0	150
136	Marathon Healthcare Center of Norwalk	Norwalk	150	0	150

137	Marathon Healthcare Center of Prospect	Prospect	120	0	120
138	Marathon Healthcare Center of Torrington	Torrington	90	0	90
139	Marathon Healthcare Center of Waterbury	Waterbury	120	0	120
140	Marathon Healthcare Center of West Haven	West Haven	98	0	98
141	Marlborough Health Care Center	Marlborough	120	0	120
142	Marshall Lane Manor	Derby	0	120	120
143	Mary Elizabeth Nursing Center, Inc.	Mystic	60	0	60
144	Mary Wade Home, Inc., The	New Haven	60	0	60
145	Masonic Healthcare Center	Wallingford	380	2	382
146	Mattatuck Health Care Facility, Inc.	Waterbury	0	43	43
147	Matulaitis Nursing Home	Putnam	119	0	119
148	McLean Health Center	Simsbury	153	1	154
149	Meadowbrook of Granby	Granby	80	10	90
150	Meriden Center	Meriden	130	0	130
151	Meridian Manor Corporation	Waterbury	94	0	94
152	Middlebury Conv. Home, Inc.	Middlebury	58	0	58
153	Middlesex Health Care Center	Middletown	150	0	150
154	Milford Health Care Ctr., Inc	Milford	120	0	120
155	Miller Memorial Community, Inc.	Meriden	79	14	93
156	Monsignor Bojnowski Manor	New Britain	60	0	60
157	Montowese Health & Rehab. Ctr., Inc.	North Haven	120	0	120
158	Mystic Manor, Inc.	Mystic	100	0	100
159	Nathaniel Witherell	Greenwich	202	0	202
160	New Milford Nursing Home	New Milford	99	0	99
161	Newington Health Care Center	Newington	180	0	180
162	Noble Horizons	Salisbury	61	30	91
163	Northbridge Health Care Center	Bridgeport	145	0	145
164	Norwichtown Rehab. & Care Center	Norwichtown	120	0	120
165	Notre Dame Conv. Home, Inc.	Norwalk	60	0	60
166	Nursing Care Center of Bristol	Bristol	132	0	132
167	Nutmeg Pavilion Healthcare	New London	140	0	140
168	Oakcliff Convalescent Home, Inc.	Waterbury	60	0	60
169	Orange Health Care Center	Orange	0	60	60
170	Orchard Grove Specialty Care Center	Uncasville	110	20	130
171	Park Place Health Center	Hartford	150	0	150
172	Parkway Pavilion Healthcare	Enfield	140	0	140
173	Pendleton Health & Rehab. Center	Mystic	120	0	120
174	Pierce Memorial Baptist Home, Inc.	Brooklyn	43	29	72
175	Pilgrim Manor	Cromwell	60	0	60
176	Plainville Health Care Center, Inc.	Plainville	173	0	173
177	Pope John Paul II Center for Health Care	Danbury	141	0	141
178	Portland Care and Rehab. Center, Inc.	Portland	65	0	65
179	Regency House of Wallingford, Inc.	Wallingford	130	0	130
180	Ridgeview Health Care Center, Inc	Cromwell	85	0	85
181	River Glen Health Care Center	Southbury	120	0	120
182	Riverside Health and Rehabilitation Center	East Hartford	345	0	345
183	Rose Haven, Ltd.	Litchfield	25	0	25
184	Saint Camillus Health Center	Stamford	124	3	127

185	Saint Joseph's Living Center	Windham	120	0	120
186	Saint Joseph's Manor	Trumbull	274	0	274
187	Saint Joseph's Residence	Enfield	25	0	25
188	Salmon Brook Center	Glastonbury	130	0	130
189	Saybrook Conv. Hosp., Inc.	Old Saybrook	120	0	120
190	Seabury Health Center	Bloomfield	60	0	60
191	Shady Knoll Health Center, Inc	Seymour	128	0	128
192	Sharon Health Care Center	Sharon	88	0	88
193	Shelton Lakes Res. & Health Care Ctr.	Shelton	59	0	59
194	Sheriden Woods Health Care Center	Bristol	146	0	146
195	Silver Springs Care Center	Meriden	149	10	159
196	Sister Anne Virginie Grimes Health Center	New Haven	125	0	125
197	Skyview Center	Wallingford	97	0	97
198	Smith House Skilled Nursing Fac.	Stamford	128	0	128
199	Southington Care Center	Southington	130	0	130
200	Sterling Manor	East Hartford	90	0	90
201	Subacute Center of Bristol	Forestville	120	0	120
202	Suffield House, The	Suffield	120	0	120
203	Talmadge Park	East Haven	90	0	90
204	The Guilford House, LLC	Guilford	60	0	60
205	The New Coleman Park Health & Rehab.	Bridgeport	100	0	100
206	The Rosegarden Health & Rehab. Center,	Waterbury	82	0	82
207	The Summit at Plantsville	Plantsville	150	0	150
208	Trinity Hill Care Center, LLC	Hartford	114	0	114
209	Twin Maples Healthcare, Inc.	Durham	44	0	44
210	Valerie Manor	Torrington	151	0	151
211	Vernon Manor Health Care Center	Vernon	120	0	120
212	Villa Maria Convalescent Home	Plainfield	62	0	62
213	Village Manor Health Care, Inc.	Plainfield	90	0	90
214	Wadsworth Glen Health Care & Rehab Center	Middletown	102	0	102
215	Walnut Hill Care Center	New Britain	180	0	180
216	Waterbury Extended Care Facility	Watertown	110	0	110
217	Watertown Convallarium	Watertown	46	0	46
218	Watrous Nursing Center	Madison	45	0	45
219	Waveny Care Center	New Canaan	76	0	76
220	West Hartford Health & Rehab. (Brookview)	West Hartford	160	0	160
221	West River Health Care Center	Milford	120	0	120
222	West Rock Health Care Facility	New Haven	26	64	90
223	Westfield Care and Rehab. Center	Meriden	120	0	120
224	Westport Health Care Center	Westport	120	0	120
225	Westside Care Center	Manchester	189	1	190
226	Westview Nursing Care & Rehab. Center	Dayville	103	0	103
227	Wethersfield Health Care Center	Wethersfield	290	0	290
228	Whitney Center	Hamden	59	0	59
229	Whitney Manor Convalescent Center	Hamden	150	0	150
230	William & Sally Tandet Center for Cont. Care	Stamford	130	0	130
231	Wilton Meadows Health Care Center	Wilton	148	0	148
232	Windsor Rehabilitation and Health Center	Windsor	120	0	120

233	Wintonbury Care Center, LLC	Bloomfield	150	0	150
234	Wolcott Hall Nursing Center, Inc	Torrington	87	0	87
235	Wolcott View Manor	Wolcott	129	0	129
236	Woodlake at Tolland	Tolland	100	0	100
	Totals		28,235	901	29,136

	Town				
237	Essex Meadows Health Center (Ccrc)	Essex	45		
238	Avalon - Stonridge	Mystic	38		
239	Yale University Health Services In-Patient Care Facility	New Haven	14		
		North			
240	Evergreen Woods Health Center (Ccrc)	Branford	50		
241	Meadow Ridge (Ccrc)	Redding	50		
242	East Hill Woods Health Center (Ccrc)	Southbury	35		
243	Pomperaug Woods Health Center (Ccrc)	Southbury	30		
244	Edgehill Health Center (Ccrc)	Stamford	60		
			<u>322</u>	0	322
			28,557	901	29,458

Appendix H: Assistive Technology Survey

Assistive Technology Evaluation

Check only one answer for each question or statement, unless instructed to do otherwise.

Living situation

1. Where do you currently live?
 - My own house or condominium/townhouse
 - My own apartment
 - Supervised living apartment, group home, or other community living arrangement
 - Community training home
 - With my parent/s in their home
 - With other relatives in their home
 - Housing complex for seniors or people with disabilities
 - Assisted living
 - Other (describe) _____

2. Whom do you currently live with? Check all that apply.
 - No one - I live alone
 - With a live-in paid assistant
 - With a spouse or partner
 - With my children under age 18
 - With my parent/s
 - With my children age 18 or over
 - With another relative
 - With a friend or roommate in a group home or a supervised living arrangement
 - Other (describe) _____

Health

3. Overall, how would you rate your health during the past month?
 - Excellent
 - Good
 - Fair
 - Poor

4. Do you need help from assistive devices or another person for any of the following activities because of a disability or health problem? Please tell me how much help you need with each activity using the following responses: you can do it by yourself, you can do it with the help of assistive devices, you can do it only with help from someone else, or you cannot do the activity at all. Check only one box for each statement.

	<u>By yourself</u>	<u>With help from assistive devices</u>	<u>Only with help from someone else</u>	<u>Cannot do it at all</u>
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping for groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing routine household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing money, including keeping track of bills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking medications correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting to places out of walking distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking a bath or shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in and out of a bed or chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting around inside the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How many paid personal assistants, or other paid helpers that you hire, work for you at least once a month?

- None
- 1-2
- 3-4
- 5-6
- 7 or more

6. On average, how many total hours of paid assistance do you receive each week from all your personal assistants or other paid helpers hired by you?

_____ hours per week

7. Now think about any unpaid assistance you receive from family or friends. On average, how many total hours of unpaid assistance do you receive each week from family or friends?

_____ hours per week

8. How physically accessible for you are your home, your workplace, or other places you want to go? Please tell me how accessible each one is for you overall: totally accessible, somewhat accessible, or not accessible at all. Check only one box for each statement.

a. How accessible for you is your home or residence?

- Totally accessible
- Somewhat → Please explain: _____
- Not at all → Please explain: _____

b. How accessible for you is your workplace?

- Totally accessible
- Somewhat → Please explain: _____
- Not at all → Please explain: _____
- I do not work

c. How accessible for you are the places where you want to shop or do errands?

- Totally accessible
- Somewhat → Please explain: _____
- Not at all → Please explain: _____

d. How accessible for you are any recreation or leisure activities you want to do in the community?

- Totally accessible
- Somewhat → Please explain: _____
- Not at all → Please explain: _____

Assistive Technology

9. Assistive technology is defined as any item or piece of equipment that is used to help maintain, improve, or increase functioning in all aspects of life. Some people use assistive devices or technology to help them at home or at work. Please tell me if you do not need it, currently use it, or do need it but do not have each assistive technology or device. Check only one box for each statement.

	<u>I do not need it</u>	<u>I currently use it</u>	<u>I do need it, but do not have it</u>
Building modifications (such as entrance ramps, expanded doorways, accessible space, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility aids (such as electric wheelchair, stair lift, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation aids (such as lift van, adaptive driving controls, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer access aids (such as touch screens, keyless entry, voice to text software, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication aids (such as communication boards, voice activated telephone, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Devices for people who are deaf (such as TDD, TTY, phone relay services, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Devices for people who are blind or legally blind (such as Braille translation software, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental controls – Equipment to help control items in your environment by voice or switch activation, such as your telephone, lights, TV, climate controls, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 10 How do you think an assistive technology device might help you? (*Probe if necessary: What activities do you want to do that an assistive technology device might help you with?*)

11. Where have you gotten information about what assistive technology is available?

12. What concerns do you have regarding assistive technology?

13. Please tell me how much you agree or disagree with the following statements, using the following responses: strongly agree, agree, disagree, or strongly disagree. Check only one box for each statement.

	Strongly agree	Agree	Disagree	Strongly disagree	
I have the right assistive technology to easily live at home.					
I have the right assistive technology to work at my job.					I am not working

Social Support

14. Overall, how satisfied are you with your life in general?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

15. If you needed some extra help, could you count on any family or friends to help you with daily tasks like grocery shopping, cooking, or giving you a ride?

- No
- Yes

16. Do you currently receive this type of extra unpaid help from family or friends at least once a week?

- Yes, I currently receive unpaid help
- No, but I could use some unpaid help
- I do not need any unpaid help

17. How often do you participate in any community activities or groups, such as a community center, social group, advocacy group, religious group, support group, sports group, or any other community group?

- Never or almost never
- Once or twice a year
- Every few months
- Once or twice a month
- Once a week or more

18. How many days per week, on average, do you leave home for any reason?
- Less than one day per week 4-6 days per week
 1-3 days per week Every day
19. Is the number of days you leave home each week the right amount for you?
- Yes, I go out enough
 No, I want to go out more
 No, I want to go out less
20. What keeps you from going out more often? Check all that apply.
- Nothing, I go out as much as I want Financial concerns
 Health concerns No person to assist me
 Emotional concerns Accessibility issues
 Lack of transportation Other _____
 Lack of assistive technology

General Information

21. What is your marital status?
- Married Separated Never married
 Widowed Divorced Living together as though married
22. What is the highest grade or year you finished in school?
- 8th grade or less Some college
 Some high school Two-year college degree
 High school diploma or GED Four-year college degree
 Technical school/community college Post graduate degree
23. Are you currently employed, volunteering, or going to school? Check all that apply.
- Work full time Homemaker Attend school
 Work part time Volunteer
24. Which category best describes your total monthly household income from all sources before taxes? Include income such as wages, salaries, Social Security, retirement benefits, veteran's benefits, public assistance, investment income, or any other income.
- Less than \$500 each month \$4,000 - \$4,999
 \$500 - \$999 \$5,000 - \$6,999
 \$1,000 - \$1,999 \$7,000 - \$8,999
 \$2,000 - \$2,999 \$9,000 - \$12,499
 \$3,000 - \$3,999 \$12,500 or more a month
25. Check all sources of income you receive. Check all that apply.
- Wages/Salary Public assistance Family
 Veteran's benefits Retirement benefits Other: _____
 Social Security Investment income

26. Is there anything else you would like to add?

NOTE: The following questions are added for the follow up interviews:

27. Please indicate how much you agree or disagree with the following statements using these responses: strongly agree, agree, disagree, or strongly disagree. Check only one box for each statement.

	Strongly agree	Agree	Disagree	Strongly disagree
I accomplished the goals that I wanted to with this assistive technology.				
I would recommend this assistive technology to other people with similar disabilities.				
I am satisfied with the assistive technology that I received.				

28. Please tell me why you either are, or are not, satisfied with the assistive technology that you received. *(Probe if necessary: What do you especially like about the assistive technology you received? What would you change to make yourself more satisfied with the assistive technology you received?)*

29. Please think about the company or people who set up and maintain your assistive technology. Then tell me how much you agree or disagree with the following statements using these responses: strongly agree, agree, disagree, or strongly disagree. Check only one box for each statement.

	Strongly agree	Agree	Disagree	Strongly disagree
I am confident of getting the assistive technology services I need when I need them.				
I can always reach someone for help with my assistive technology whenever I need it.				
The people who provide my assistive technology treat me with courtesy and respect.				

30. You received a [name of AT device] from the [program name] long-term loan program. Are you still using the AT that you received?
- No
 - Yes

30a. [Open text box for additional comments.]

31. **If No to Question 30:** May we come and take the [name of AT device] (if appropriate) to loan out to someone else who may need it?
- No
 - Yes
 - Not applicable (answered Yes to Q 30)

31a. [Open text box for additional comments.]

32. Do you need more training on how to use the [name of AT device] you received?
- No
 - Yes

32a. [Open text box for additional comments.]

33. **If Yes to Question 32:** Would you like to have a Tech Mentor provide support and orientation/basic training?
- No
 - Yes
 - Not applicable (answered No to Q 32)

33a. [Open text box for additional comments.]

Appendix I: Curriculum Vitae – Julie Thompson Robison

Additional information regarding Evaluation Qualifications

The PI and her former colleague, Dr. Cynthia Gruman (now an employee of Mathematica Policy Research, Inc.), have conducted evaluations for five of Connecticut's Systems Change Grants: Nursing Facility Transition Grant (NFTG), Medicaid Infrastructure Grant (MIG), Level of Need and Resource Allocation: Independence Plus Initiative, Incident Reporting, Abuse, Neglect, Restraints and Injuries: A Benchmarking Model, and Community Integrated Personal Assistant Support Services (C-PASS). Dr Robison is also evaluating the Social Security Administration's Benefit Offset Pilot Demonstration (2 for 1), the newly awarded Nursing Home Diversion Modernization Grant from AOA (Fortinsky and Robison, co-PIs), and has recently conducted a Statewide long term care needs assessment (2007).

Dr. Robison and her research team have an integral understanding of Connecticut's long term care system including the State Medicaid system. The MFP evaluation will build on six years of evaluation work conducted by this group for the NFTG, and the subsequent State-funded Nursing Facility Transition Program (NFTP). Further, Dr. Robison has many years of experience in conducting nursing home and community-based health services research (see attached CV).

The University of Connecticut Health Center (UCHC) research team is part of the University's Center on Aging, a geriatric research, clinical and education center within the school of medicine. The Center on Aging provides office space and administrative support to the research team. In addition to the PI, the research team comprises three highly experienced research assistants (two with master's degrees in gerontology), a policy analyst (JD, MBA), and a statistician and data manager. The PI will supervise all aspects of the evaluation, and one research assistant will manage the day-to-day activities for the project. The research team will maintain a tracking database using Microsoft Access to implement the evaluation data collection activities.

CURRICULUM VITAE

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Office: (860) 679-4278
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E-mail: jrobison@uchc.edu

Education:

1990	B.A.	Georgetown University, Washington DC	Psychology/Art History
1993	M.A.	Cornell University, Ithaca NY	Human Development and Family Studies
1995	Ph.D.	Cornell University, Ithaca NY	Human Development and Family Studies
6/95 – 2/97		Postdoctoral Fellow in the Epidemiology of Aging Yale University School of Medicine	Epidemiology and Public Health

Professional Experience:

1/00 – Assistant Professor of Medicine, University of Connecticut School of Medicine
6/97 – 12/05 Research Affiliate, Yale University School of Medicine, Department of Epidemiology and Public Health
1/97 – 2/05 Senior Scientist, Braceland Center for Mental Health and Aging, Institute of

Living/Hartford Hospital

1/98 – 5/98 Adjunct Faculty, University of Connecticut, Department of Human Development and Family Relations
7/95 – 1/97 Senior Research Associate, Braceland Center for Mental Health and Aging, Institute of Living/Hartford Hospital's Mental Health Network
7/95 – 6/97 Research Associate, Yale University School of Medicine, Claude Pepper Older Americans Independence Center
9/91 – 8/95 Research Assistant, "Women's Roles and Well-Being Project," Cornell University
9/92 – 8/95 Research Assistant, Cornell Applied Gerontology Research Institute, Cornell University
9/94 – 5/95 Teaching Assistant, Human Development and Family Studies, Cornell University
6/92 – 5/93 Research Assistant, Bronfenbrenner Life Course Center, Cornell University
6/90 – 5/91 Psychologist, Longitudinal Study of Alzheimer's Disease, Laboratory of Neurosciences, National Institute on Aging

1/90 – 5/90 Research Assistant, Longitudinal Study of Alzheimer's Disease, Laboratory of Neurosciences, National Institute on Aging

Research Funding:

- 6/95 – 2/97 Postdoctoral Fellow in the Epidemiology of Aging. Training grant, National Institute on Aging, \$40,000.
- 2/97 – 1/99 Co-Principal Investigator/Project Manager. Behavioral Symptoms Associated with Alzheimer's Disease and Related Dementias: Characteristics and Predictors of Effective Management, Patrick and Catherine Weldon Donaghue Medical Research Foundation, \$120,000.
- 2/98 – 6/99 Co-Investigator/Project Manager. Effects of Depression on Elderly Patients' Attitudes About Life Sustaining Treatments and Assisted Suicide, Hartford Hospital, \$50,000.
- 5/98 – 4/99 Co-Investigator. Geriatric Psychiatry Inpatient Projects, Hartford Hospital, \$20,000.
- 9/98 – 12/99 Co-Investigator. Process Evaluation of the Integrated Care Program, State of CT Dept. of Social Services and The Robert Wood Johnson Foundation, \$24,000.
- 11/98 – 9/01 Co-Investigator. Formal Long Term Care Services: Attitudes and Behaviors of Older Adults in the Community, State of CT Department of Social Services and The Robert Wood Johnson Foundation, \$34,383.
- 3/99 – 5/00 Co-Principal Investigator. Depression and Related Psychiatric Symptoms in Puerto Rican Middle Aged and Older Adults: Culturally Sensitive Screening and Obstacles to Treatment, Hartford Hospital Research Fund, \$87,639.
- 7/00 – Faculty. Geriatric Fellowship Research Curriculum, National Institute on Aging/University of Connecticut Center on Aging, \$12,500 annually.
- 7/00 – 7/01 Principal Investigator: Service Use in Depressed Middle-Aged and Older Puerto Rican Patients: Does a Family-Focused Intervention Make a Difference? Hartford Hospital Research Fund, \$49,988.
- 8/00 – 7/01 Principal Investigator: Partners in Caregiving in a Special Care Environment, HCR ManorCare Foundation, \$24,368.
- 4/01 – 4/04 Site Principal Investigator: Improving Access to Mental Health Services for Older Hartford Residents, Patrick and Catherine Weldon Donaghue Medical Research Foundation, \$996,600.
- 7/01 – 6/03 Principal Investigator: Development of Need Specific Alzheimer's Care Units: A Process and Outcomes Evaluation, Alzheimer's Resource Center of CT, \$15,000.
- 12/01 – 11/05 Co-Investigator: The Institute of Living's Program for the Residents of Elderly Housing Facilities, Hartford Foundation for Public Giving, \$283,700.
- 10/01 – 9/02 Consultant: Partners in Caregiving, National Institute on Aging, subcontract through Cornell University, \$33,500.
- 8/02 – 8/05 Principal Investigator: Partners in Caregiving in a Special Care Environment, Alzheimer's Association, \$239,766.
- 9/03 – 12/04 Principal Investigator: Burden and Morbidity in Families of People with Psychotic Spectrum Disorders, Hartford Hospital Open Competition Funds, \$49,995.
- 10/03 – 9/05 Co-Investigator, CT Site Director: The Retention Specialist Program: Testing a Model Workplace Innovation, Robert Wood Johnson Foundation, \$500,000.

- 8/04 – 3/05 Collaborator: Video Intervention Project: Depression and Anxiety in Older Puerto Rican Adults, Aetna Foundation, \$70,000.
- 10/03 – 9/07 Co-Investigator: Level of Need and Resource Allocation: Independence Plus Initiative, Centers for Medicare and Medicaid Services/CT Department of Mental Retardation. \$155,000.
- 10/03 – 9/07 Co-Investigator: Incident Reporting, Abuse, Neglect, Restraints and Injuries: A Benchmarking Model, Centers for Medicare and Medicaid Services/CT Department of Mental Retardation. \$15,000.
- 1/05 – 2/06 Co-Principal Investigator: Services and Housing Options for Older Adults in the Ellington City Council, Ellington, CT, \$24,000.
- 4/05 – 4/08 Co-Principal Investigator: Benefit Offset Pilot Demonstration Project, Social Security Administration/CT DSS Bureau of Rehabilitation Services, \$237,297.
- 1/05 – 12/05 Co-Principal Investigator: Medicaid Infrastructure Grant I, Centers for Medicare and Medicaid Services/CT DSS Bureau of Rehabilitation Services, \$100,000.
- 4/05 – 6/05 Co-Principal Investigator: Senior Care Options (SCO) Program Evaluation - Phase I: Enrollment Trends, Massachusetts Executive Office of Health and Human Services/UMass Health Policy Partnership, \$12,102.
- 5/05 – 9/07 Co-Principal Investigator: Community-Integrated Personal Assistant Support Services Evaluation, Centers for Medicare and Medicaid Services/UConn AJ Papanikou Center for Excellence in Developmental Disabilities Education, Research and Service, \$9,000.
- 7/05 – 12/07 Co-Principal Investigator: Nursing Facility Transition Program, Connecticut Legislature \$20,000.
- 11/05 – 6/06 Co-Principal Investigator: Senior Care Options (SCO) Program Evaluation - Phase II: Member Experiences, Massachusetts Executive Office of Health and Human Services/UMass Health Policy Partnership, \$42,585.
- 1/06 – 12/06 Co-Principal Investigator: Medicaid Infrastructure Grant II, Centers for Medicare and Medicaid Services/CT DSS Bureau of Rehabilitation Services, \$707,925.
- 5/06 – 1/09 Principal Investigator: Autism Pilot Project Evaluation, CT Department of Mental Retardation, \$33,245.
- 7/06 – 6/08 Principal Investigator: An Assessment of Connecticut Residents' Long Term Care Needs and Adequacy of the LTC System, Connecticut Legislature & CT Long Term Care Ombudsman Program, \$380,000.
- 11/06 – 9/10 Co-Principal Investigator: Massachusetts Systems Transformation Grant – External Validator, Centers for Medicare and Medicaid Services/University of Massachusetts Center for Health Policy and Research, \$49,999.
- 1/07 – 12/09 Principal Investigator: Connecticut Bureau of Rehabilitation Services Mental Health Pilot, CT DSS Bureau of Rehabilitation Services, \$166,045.
- 1/07 – 12/09 Principal Investigator: Medicaid Infrastructure Grant III, Centers for Medicare and Medicaid Services/CT DSS Bureau of Rehabilitation Services, \$887,335.
- 1/07 – 12/09 Principal Investigator: Money Follows the Person Rebalancing Demonstration, Centers for Medicare and Medicaid Services/CT DSS, \$450,015.
- 6/07 – 6/08 Principal Investigator: Holyoke, Massachusetts Senior Needs Assessment, City of Holyoke, MA, \$27,102.
- 6/07 – 5/09 Co-Investigator: Information and Help-Seeking Experience among Hispanic Family Caregivers, Alzheimer's Association, \$240,000.

10/07 – 4/09 Co-Principal Investigator: Nursing Home Diversion and Modernization Grant Evaluation, Administration on Aging/CT DSS, \$57,745.

Reviewer:

Journal of Applied Gerontology

Journal of Gerontology, Social Sciences

Journal of Marriage and the Family

Journal of Psychosomatic Research

Milbank Quarterly

Research on Aging

National Alzheimer's Association annual grants

Gerontological Society of America's annual meeting abstracts

Professional Memberships:

Gerontological Society of America

Current Committee Assignments:

Alzheimer's Resource Center of Connecticut, Inc. Board of Trustees

CT Long Term Care Ombudsman Program Workgroup on Challenging Behaviors

Donaghue Foundation Patient Safety Research Initiative Advisory Committee

Ethel Donaghue Center for Translating Research into Practice and Policy Executive Committee

Journal of Applied Gerontology Editorial Board

Medicaid Infrastructure Grant Steering Committee, ex-officio

Money Follows the Person Rebalancing Demonstration Steering Committee, ex-officio

Past Committee Assignments:

CT Coalition for End of Life Care

Hartford Hospital Art Committee

Peer Reviewed Original Research Publications:

Moen, P., Robison, J., & Fields, V. (1994). Women's work and caregiving roles: A life course approach. *Journal of Gerontology: Social Sciences*, 49(4), S176-S186.

Moen, P., Robison, J., & Dempster-McClain, D. (1995). Caregiving and women's well-being: A life course approach. *Journal of Health and Social Behavior*, 36, 259-273.

Pillemer, K., Moen, P., Krout, J., & Robison, J. (1995). Setting the White House Conference on Aging agenda: Recommendations from an expert panel. *The Gerontologist*, 35(2), 258-261.

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Gill, T. M., Robison, J. T., & Tinetti, M. E. (1997). Predictors of recovery of ADL function among disabled older persons living in the community. *Journal of General Internal Medicine*, 12, 757-762.

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- Robison, J. (2002, May 10). *Partners in Caregiving in a Special Care Environment*. Presented at the Connecticut Alzheimer's Association Education Conference, Cromwell, CT.
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Honors:

2002 – 2004 Marquis Who's Who in America, 56th Edition
11/93 Pre-Dissertation Paper Award, Gerontological Society of America, BSS section
9/93 – 8/94 Virginia F. Cutler Fellowship, Serby-Gildea Scholarship, Anna Cora Smith
Fellowship, Alumni Fellowship, Cornell University
6/93 – 8/93 Cornell University Graduate School Summer Fellowship
11/92 Feldman Fellowship
9/91 – 5/92 Sage Graduate Fellowship
5/90 – Phi Beta Kappa

Appendix J: Participant Survey

Please use this document to report information about consumers as they apply for services under the project. Please complete one form for each new consumer.

Consumer Contact Information

1) Center:

2) Consumer's Nickname: Salutation: (Mr., Ms., Sr., etc.)

3) First Name: MI: Last Name:

4) Date of Application: (M/d/yy)

5) Name of Nursing Facility:
(If name of facility has changed, write "Name Change" after inserting current name.)

Facility Code:

Reference: See Nursing Facilities for Data Entry for a list of nursing homes and

6) Current Mailing/Home Address #1:

Room Number: *(Include only if consumer is residing in a nursing home)*

Current Mailing Address #2: *(Include Apt. # or PO Box here if consumer is in community)*

Town: State: CT Zip Code:

7) Consumer Telephone: Consumer TDD? (Check if yes)

Consumer E-Mail:

8) Alternate Contact Name:

Contact Telephone: Alternate TDD? (Check if yes)

Contact E-Mail:

9) Legal Representative:

1 = Conservator 2 = Guardian 3 = Parent 4 = None

First Name: Last Name:

Address:

City: State: CT ZIP:

Legal Rep. Limitations:

- 10) **Meets grant requirements?** (Check if yes)
- 11) **Reason not participating:**
- 12) **Date Accepted for Services:** (M/d/yy)

Consumer Demographics

- 1) **Social Security Number:** (Please **do not** include hyphens “-“)
- 2) **Medicaid Number:**
- 3) **Date of Birth:** (M/d/yy)
- 4) **Gender:**

M = Male F = Female

- 5) **Veteran?** (Check if yes)
- 6) **Spouse of Veteran?** (Check if yes)
- 7) **How did the consumer learn about the project?**

- 8) **Date the consumer learned about the project:** (M/d/yy)

- 9) **Date consumer contacted ILC:** (M/d/yy)
- 10) **Date consumer applied to the project:** (M/d/yy)
- 11) **Date consumer was admitted to the project:** (M/d/yy)

- 12) **Ethnic background of consumer:**
Ethnic background other:

<p>Reference: See Page 2, Item (1) of Instructions for Ethnic Codes</p>

13) **Disability categories:** (For multiple disabilities, check Multiple AND all that apply.)

<i>Disability Category</i>	<i>Check only if YES</i>
Cognitive	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>
Physical	<input type="checkbox"/>
Visual	<input type="checkbox"/>
Hearing	<input type="checkbox"/>
Multiple	<input type="checkbox"/>
Declined	<input type="checkbox"/>

14) **Which specific disabilities represent the primary, secondary and tertiary disabilities of the consumer?** (For instances where secondary and/or tertiary disabilities are not present, please enter Code Number 23 for “none”)

Primary Disability:
 Primary Disability Other:

Secondary Disability:
 Secondary Disability Other:

Tertiary Disability:
 Tertiary Disability Other:

Reference: See Page 2, Item (2) of Instructions for **Specific Disability Codes**

15) **Community where the consumer would like to transition:**

Preferred community:

16) **Consumer’s level of education:**

Comments/notes about education level:

Reference: See Page 3, Item (3) of Instructions for **Education Codes**

17) **Consumer’s employment history:**

How many years (in total) did the consumer work since turning age 18?

Years worked:

Reference: See Page 3, Item (4) of Instructions for **Work History Codes**

What was the consumer’s highest level of earnings in any one year from wages, salary or profit from a business?

Level of earnings:

Reference: See Page 3, Item (4) of Instructions for **Earning Codes**

18) Nursing facility history at time of consumer's admission to project:

- Was the consumer discharged from a hospital to the nursing facility?
 (Check if yes)

If yes, what was the name of the hospital? [REDACTED]

- Date consumer was admitted to nursing facility: [REDACTED] (M/d/yy)
→(If the consumer has been in a number of nursing facilities consecutively, enter date admitted to the first facility.)

- Reason consumer was admitted: [REDACTED]

- What is the level of care for the consumer in the facility? [REDACTED]

Skilled (CCNH) or Intermediate

- What was the consumer's last address of record? (Town only) [REDACTED]

- Where did the consumer reside before admission to this facility? [REDACTED]

Reference: See Page 3, Item (5) of Instructions for **Former Residence Codes**

- What was the consumer's living situation before admission? [REDACTED]

Reference: See Page 4, Item (6) of Instructions for **Living Situation Codes**

- If the consumer lived with other people, were the people serving as caregivers to the consumer? (Check if yes)
- How many times (if any) was the consumer discharged to the community?
- If the consumer was discharged from a facility, what factor(s) led to readmission to a nursing facility?

Consumer Daily Living Needs

1) How does the individual's disability affect them functionally in terms of living independently?

2) Activities of Daily Living

Needs Hands on Assistance (Check if yes)	Needs Cueing or Guidance (Check if yes)	Activity
<input type="checkbox"/>	<input type="checkbox"/>	Bathing
<input type="checkbox"/>	<input type="checkbox"/>	Dressing
<input type="checkbox"/>	<input type="checkbox"/>	Transferring
<input type="checkbox"/>	<input type="checkbox"/>	Eating
<input type="checkbox"/>	<input type="checkbox"/>	Bowel/Bladder Care

3) Instrumental Activities of Daily Living

Needs Hands on Assistance (Check if yes)	Needs Cueing or Guidance (Check if yes)	Activity
<input type="checkbox"/>	<input type="checkbox"/>	Housework
<input type="checkbox"/>	<input type="checkbox"/>	Finances
<input type="checkbox"/>	<input type="checkbox"/>	Transportation
<input type="checkbox"/>	<input type="checkbox"/>	Shopping
<input type="checkbox"/>	<input type="checkbox"/>	Management of Support Services
<input type="checkbox"/>	<input type="checkbox"/>	Other IADL

Description of "Other" Instrumental Activity:

4) Are there other supports needed by the consumer? (Check if yes)

Description of other supports needed:

Consumer Placement History

References:
 See Page 4, Item (7) of Instructions for **Reason for Admission Codes**
 See Page 3, Item (5) of Instructions for **Former Residence Codes**
 See Page 4, Item (6) of Instructions for **Living Situation Codes**
 See Page 4, Item (8) of Instructions for **Reasons for Discharge**
 See Page 5, Item (9) of Instructions for **Discharge Destination Codes**

	Current Facility V	Next Previous V	Next Previous V	Next Previous V
Type of Placement				
Date Admitted (M/d/yy)				
Reason for Admission				
Former Residence				
Former Living Situation				
Discharge Date (M/d/yy)				
Reason for Discharge				
Discharge Destination				

Description of Other Living Situation:

Consumer Resource Needs and Utilization

1) Status of Resources Needed

References:
 See Page 5, Item (10) of Instructions for **Support Services Needed Codes**
 See Page 5, Item (11) of Instructions for **Support Status**

For each support needed, start at the top of the first available column (start at left) and fill down.

Support Needed					
Support Status					
Estimated Date Needed (m/d/yy)					
Total Estimated Cost					
Primary Payer					
Amount Requested					
Amount Paid					
Secondary Payer					
Amount Requested					
Amount Paid					

Description of other supports needed:

Appendix K: Transition Progress Report

Transition Progress Report – Blank

Center: Consumer ID: (To be assigned by CACIL)

Consumer First Name: Consumer Last Name:

Ending Date for Quarter:

Ending Dates
3/31/yy, 6/30/yy, 9/30/yy, or
12/31/yy

Progress in Consumer's Transition

1) Consumer's current status with the project:

Reference: See Page 2, Item (1) of Instructions for **Current Status Codes**

Reason for status:

Examples of Reasons

2 – Active On Hold – “Hospitalized”

4 – Ineligible -- “Lives in Rest Home”

5 – Withdrawn by CIL -- “Transferred to Another Advocate”

6 – Withdrew from Project -- “Chooses to stay at NF”

If the consumer was transitioned this quarter, what was the date of transition?

7 – Transitioned to Community -- “Transitioned 3/31/2003”

2) Is the Transition Time Line being used as a guide for accomplishing activities related to the consumer through

8 – D/C from Project by Project -- “Consistent lack of follow

through”

→ If No, Why Not?

3) Benchmarks achieved on the transition timeline for each month of the quarter. **(See characteristics of bench-marks in transition guide. List components of the plan that are in place.)** – Use last date of month: 1/31/xx, 2/28/xx, 3/31/xx, 4/30/xx, etc.

Reference: See Page 2, Item (2) of Instructions for **Transition Timeline Codes**

Timeline	
Reporting Date (For each month – m/d/yy)	Timeline Code

- 4) What are the three (3) most important activities that have been undertaken that demonstrate progress has been made on the timeline compared to last reporting period?

Reference: See Pages 3 and 4, Item (3) of Instructions for **Timeline Progress Indicators**

1 - 2 - 3 -

(Use '51' for "None" and '99' for Not Applicable (N/A))

Other activity indicating progress:

- 5) What are the three (3) most important barriers that have been encountered that demonstrate regression on the timeline compared to last reporting period?

Reference: See Page 4, Item (4) of Instructions for **Timeline Barrier Codes**

1 - 2 - 3 -

(Use '12' for "None" and '99' for Not Applicable (N/A))

Other barrier:

- 6) What are the three (3) most important practices that have been most influential to the success of the consumer's transition compared to last reporting period?

1 - 2 - 3 -

Reference: See Pages 5, Item (5) of Instructions for **Successful Practice Codes**

(Use '34' for "None" and '35' for Not Applicable (N/A))

Other practice:

- 7) What are the three (3) most important factors that have been most influential in delaying the progress of the consumer's transition compared to last reporting period?

1 - 2 - 3 -

Reference: See Page 6, Item (6) of Instructions for **Delaying Factors**

(Use '25' for "None" and '99' for Not Applicable (N/A))

Other delaying factor:

8) Which project tools have been used as part of this consumer's transition process?

Self Assessment (Check if yes)

→ If No, Why Not?

Transition Guide (*Spiral Bound Guide Distributed to Consumers*)

(Check if yes)

→ If No, Why Not?

Transition Resource Handbook (*Large Professional Handbook*)

(Check if yes)

→ If No, Why Not?

9) **How many people are actively involved in the consumer's Transition?** (NF Staff, Family, Friends, Community Support, etc.)

0 – None 1 – 1-3 People 2 – 4-6 People 3 – 7-10 People 4 – More than 10 people
--

Do most of these people constitute or function as a team or Circle of Support?

(Check if yes) **Comments:**

- 10) How involved is the individual in their transition? **Do not consider assistance the individual needs to accommodate their disability. (Example: For someone with quadriplegia and no access to an appropriate computer, do not consider their need for assistance with written tasks as a factor that limits their ability to be involved. Look at what they can do to accomplish this, such as using the Transitional Coordinator or Facility Social Worker to act as a scribe.)**

Reference: See Page 6, Item (7) of Instructions for **Consumer's Level of Involvement** codes

What factors have contributed to the consumer's involvement? **(personal drive/depression/anxiety, hostile or highly supportive NF environment, active or lack of active family and friends.)**

- 11) In general, how supportive is the nursing facility of the consumer's transition?

Reference: See Page 7, Item (8) of Instructions for **Nursing Facility's Level of Involvement** codes

What factors have contributed to the nursing facility's involvement?

- 12) **Estimated date of consumer's discharge (if still in facility):** (M/d/yy)
(If it is not possible to project a date at this point – use one year from the close of this quarter.)

- 13) ILC staff time (in hours) on individual's transition this reporting period:

Consumer's Community Supports

- 1) Does the consumer require housing in the community? (Check if yes)

If housing is needed:

How many bedrooms?

What is the maximum rent the consumer can afford?

What other housing requirements are necessary?

Housing Requirement	Needed? (Check if yes)
Rental subsidy needed	<input type="checkbox"/>
Wheelchair accessible?	<input type="checkbox"/>
Must have less than 6 stairs	<input type="checkbox"/>
Main entrance must be accessible	<input type="checkbox"/>
Has or is capable of roll-in shower	<input type="checkbox"/>
Must be near accessible transportation	<input type="checkbox"/>
Must accommodate live-in PA or companion	<input type="checkbox"/>
Other housing requirements*	<input type="checkbox"/>

*Other housing requirements described:

- 2) Which of the following community resources have been identified?

Community Resource	Available? (Check if yes)
Housing registry	<input type="checkbox"/>
Center for Independent Living	<input type="checkbox"/>
Part B funds of Independent Living Center	<input type="checkbox"/>
Local office of Persons with Disabilities	<input type="checkbox"/>
Local social worker	<input type="checkbox"/>
Spouse or domestic partner in community	<input type="checkbox"/>
Co-op Initiatives	<input type="checkbox"/>
Faith-based organizations	<input type="checkbox"/>

Private funding sources, such as local foundations*	<input type="checkbox"/>
Local ADA Para Transit	<input type="checkbox"/>
Local cultural centers/organizations/agencies	<input type="checkbox"/>
Local cultural options, such as theater, arts, etc.	<input type="checkbox"/>
Disability rights and advocacy available	<input type="checkbox"/>
Housing authority available in community	<input type="checkbox"/>
Local medical suppliers	<input type="checkbox"/>
Local mental health services/center	<input type="checkbox"/>
Local/State peer support – disability related	<input type="checkbox"/>
Local/State peer support – not disability related	<input type="checkbox"/>
Local recreational programs	<input type="checkbox"/>
Local senior center	<input type="checkbox"/>
Local substance abuse treatment center/program	<input type="checkbox"/>
State security deposit program	<input type="checkbox"/>
Transition house	<input type="checkbox"/>
Victim's services	<input type="checkbox"/>
Other local resources**	<input type="checkbox"/>

* Name(s) of local funding sources:

** Other local resources:

3) Please describe any ILC resources (other than grant resources) that are supporting this transition:

Remaining questions are only for consumers who have transitioned: Complete for Transitioned Consumers who have not had their case closed or who were closed this quarter. (Consumers who are Statue '7.1' or moved out of status '7.1' this quarter.)

Appendix L: Consumer Satisfaction Survey

Nursing Facility Transition Grant

Consumer Satisfaction Survey

For the following questions, please place a check mark (4) next to the correct response. Please check only one (1) response to each question.

- 1) Did you use the Self Assessment developed by the project? Yes No

If **Yes**, was it helpful? Yes No Did not use tool

- 2) Did you use the Handbook or Guide developed by the project? Yes No

If **Yes**, was it helpful? Yes No Did not use handbook/guide

- 3) Overall, how satisfied are you with your current living situation and supports?

Very Satisfied Satisfied OK, if some changes were made
 Dissatisfied Very Dissatisfied

- 4) How often do you go out into the community for recreation and enjoyment?

Several times a day Daily Several times a week Weekly
 At least monthly Less than monthly Not at all

How would you rate this activity in terms of your expectations?

Not enough – It's a problem
 Not quite as much as I would like, but it's all right
 Just about right for me
 Maybe a little more than I would like
 Too much – It's a problem

- 5) How often do you receive visits from friends and family?

Several times a day Daily Several times a week Weekly
 At least monthly Less than monthly Not at all

How would you rate the amount of visits from friends/family in terms of your expectations?

- Not enough – It's a problem
- Not quite as much as I would like, but it's all right
- Just about right for me
- Maybe a little more than I would like
- Too much – It's a problem

6) How often do you communicate (telephone, e-mail, etc.) with other people aside from making appointments or arranging services?

- Several times a day Daily Several times a week Weekly
- At least monthly Less than monthly Not at all

How would you rate the amount of communication with other people in terms of your expectations?

- Not enough – It's a problem
- Not quite as much as I would like, but it's all right
- Just about right for me
- Maybe a little more than I would like
- Too much – It's a problem

7) How often are you alone?

- Several times a day Daily Several times a week Weekly
- At least monthly Less than monthly Not at all

How would you rate the amount of time you're alone in terms of your expectations?

- Not enough – It's a problem
- Not quite as much as I would like, but it's all right
- Just about right for me
- Maybe a little more than I would like
- Too much – It's a problem

8) How often do you have contact with people in your life (other than those paid to help you) to help you figure things out and who are supportive to you?

- Several times a day Daily Several times a week Weekly
 At least monthly Less than monthly Not at all

How would you rate the amount of this type of support in terms of your expectations?

- Not enough – It's a problem
 Not quite as much as I would like, but it's all right
 Just about right for me
 Maybe a little more than I would like
 Too much – It's a problem

9) How often do you have personal assistance and support from people who are paid or from an agency or organization that is helping you?

- Several times a day Daily Several times a week Weekly
 At least monthly Less than monthly Not at all

How would you rate the amount of this type of support in terms of your expectations?

- Not enough – It's a problem
 Not quite as much as I would like, but it's all right
 Just about right for me
 Maybe a little more than I would like
 Too much – It's a problem

10) Are the following sufficient for your needs?

- | | | |
|---------------------------|--|---|
| Financial resources | <input type="checkbox"/> Yes, sufficient | <input type="checkbox"/> No, not sufficient |
| Housing | <input type="checkbox"/> Yes, sufficient | <input type="checkbox"/> No, not sufficient |
| Transportation | <input type="checkbox"/> Yes, sufficient | <input type="checkbox"/> No, not sufficient |
| Making your own decisions | <input type="checkbox"/> Yes, sufficient | <input type="checkbox"/> No, not sufficient |
| Feeling safe | <input type="checkbox"/> Yes, sufficient | <input type="checkbox"/> No, not sufficient |
| Privacy | <input type="checkbox"/> Yes, sufficient | <input type="checkbox"/> No, not sufficient |
| Overall living situation | <input type="checkbox"/> Yes, sufficient | <input type="checkbox"/> No, not sufficient |

For the areas where your supports are not sufficient, please tell us what problems you are facing and how you are managing the situation.

11) Are there other problems you are encountering that you would like to tell us about?

12) What is the best part of the way you are now living – What in your life right now makes you happy?

13) Since you moved out of the nursing facility, have you had contact with anyone from the Nursing Facility Transition Project or any of the people who helped you leave the nursing facility?

Yes No

If **Yes**, who has been in contact with you?

Did you find the contact helpful? Yes No Did not have contact

14) Would you like the Transition Coordinator or anyone who helped you leave the facility to contact you? Yes No

If **Yes**, who would you like to contact you?

15) May we call or visit you to discuss this survey? Yes No

If **Yes**, please provide us with your telephone number and the best time to call below.

Phone number: _____ Best Time to call: _____

Just a few more questions: There has been much interest about individuals who have transitioned from nursing facilities; whether they worked in the past and if any of them have returned to work or are seeking work. Please tell us:

Are you now working? (Check all that apply)

Yes Full-time Part-time
 Temporary Volunteer

I have worked since returning to the community, but am not working now.

No Retired I'm not interested at this time.
 I would like to explore options for working.

In the past:

1. Have you ever worked for pay?

Yes
 No

If No, have you ever worked in a non-paying (Volunteer Situation?)

Yes
 No

If you have worked for pay in the past, and are not working now, please tell us a little more about your previous work experience:

2. When did you stop working?
- | | |
|---|---|
| <input type="checkbox"/> Less than 3 months ago | <input type="checkbox"/> 6 months to a 1 year ago |
| <input type="checkbox"/> 3 to 6 months ago | <input type="checkbox"/> 1 or more years ago |
3. How long did you work for your last employer?
- | | |
|---|---|
| <input type="checkbox"/> Less than 6 months ago | <input type="checkbox"/> 2 years to up to 5 years |
| <input type="checkbox"/> 6 months to less than 1 year | <input type="checkbox"/> 5 years or more |
| <input type="checkbox"/> 1 year to less than 2 years | |
4. How many hours did you typically work each week at your last job? _____/ week
5. What was your average hourly wage before taxes for your last job? Was it...
- | | |
|---|--|
| <input type="checkbox"/> Less than \$7.00 an hour | <input type="checkbox"/> \$16 – 19.99 an hour |
| <input type="checkbox"/> \$7 – 9.99 an hour | <input type="checkbox"/> \$20 – 24.99 an hour |
| <input type="checkbox"/> \$10 – 12.99 an hour | <input type="checkbox"/> \$25 or more an hour |
| <input type="checkbox"/> \$13 – 15.99 an hour | <input type="checkbox"/> Other: \$ _____ per _____ |
6. What best describes your last job?
- A job with competitive wages in the community which you applied for, and was not set aside for persons with a disability,
 - You were self employed.
 - A job with competitive wages in the community which is set aside for persons with a disability – only people who have some type of disability can apply
 - Supportive employment – Using a job coach or other individualized support to help you get or work at a job
 - Vocational program or group supported employment
 - Transitional employment where you are placed in a job for limited time by an agency
 - Sheltered workshop or enclave
 - Other (write in) _____
7. What did having a job mean to you?

8. How much did you like your last job? Did you like it....
- | | |
|------------------------------------|--|
| <input type="checkbox"/> Very much | <input type="checkbox"/> Not very much |
| <input type="checkbox"/> Somewhat | <input type="checkbox"/> Not at all |
9. At this time, are you actively looking for a job?
- Yes
- No
10. During the next 12 months, how likely is it that you will get a job? Check only one.
- | | |
|--|--|
| <input type="checkbox"/> Very likely | <input type="checkbox"/> Not likely |
| <input type="checkbox"/> Somewhat likely | <input type="checkbox"/> Not at all likely |
11. What are the barriers that keep you from working?

Thank You!

Your responses are important in changing the community support systems in Connecticut.

Appendix M: Incidence Reporting

Incident Reporting

Connecticut employs strict protocols regarding the reporting of abuse, neglect, and exploitation. Each of the three operating agencies for the delivery of services under MFP has demanding and prescriptive procedures for incident and management reporting systems. These procedures are dictated by State statute and regulation. While the procedures and managing systems are different, each has the same objective: to identify, address and seek to prevent instances of abuse, neglect and exploitation. See the table below for a summary of each agencies' procedures. Below is a complete listing of resources that illustrate the ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment, and are told how to report concerns or incidents of abuse, neglect and exploitation. Training is provided to all participants and involved family or other unpaid caregivers via transitional services and by case managers.

For critical incidences reported directly to the MFP program through the triage and 24 hour hotline, MFP will ensure that all reporting requirements are met. The hotline staff will adopt reporting strategy meeting the strictest protocol for all three agencies. For example, all incidences of abuse and neglect will be reported immediately to MFP program director and operating agency contact. In addition, incidences regarding sexual abuse will be reported to state police. All other critical incidences involving serious impacts to participants will be reported within 3 hours to the MFP office and operating agency contact. If the incidence is not an immediate issue and does not put the participant at risk, then the triage contractor must contact the MFP program and operating agency within 48 hours. Written reports are expected within one business day to the MFP office and the operating agency contact. All critical incidences will be followed up on within 30 days or the specified earlier deadline specified by regulation. Once the program office or operating agency is contacted, any requirements that fall to the MFP staff will be met. For example, the staff is required to communicate incidences to the family and remainder of the team within 24 hours. In addition, MFP staff will meet all reporting deadlines (e.g., reports to family, Case Manager or broker). Reporters are all staff employed directed by the individual family or provider agency including Case Manager, Social Worker, cognitive behaviorist, conservator, triage and 24 hour hotline staff, and MFP staff.

Table M. Summary of Agency Protocols for Reporting of Abuse, Neglect and Exploitation

Agency	Level of reporting	Reporters	Timeframe
Persons served by Department of Social Services (DSS) waivers and programs PSE Statute 17b-450-461; Adults and elders	Serious incident involving abuse/neglect or other immediate risk to participant	All staff employed directly by individual, provider or agency including case manager, central office staff. In addition, clergy, police officers, medical professional and nursing home staff are mandatory reporters for elders	Immediate contact to appropriate agency; written report no later than 5 PM next business day. Data entered into on-line data system Immediate contact to family, case manager, broker
	Sensitive incident	Same	Reported no later than 48 hours; Data entered into on-line data system
Persons served by Department of Developmental Services (DDS) waivers and programs I.F.PO.001	Abuse/ Neglect and other critical incidents	All staff employed directly by individual, provider or agency including case manager, central office staff.	Immediate contact to appropriate agency; reports transcribed and faxed to Division of Investigation. In matters involving sexual abuse, State police are notified. Immediate contact to family, case manager, broker
	Non-critical incidents	Same	Submitted within 5 business days and entered into CAMRIS.
Persons served by Department of Mental Health & Addiction Services (DMHAS) waivers and programs Commissioner's Policy Statement No. 81	Critical Incident including abuse and neglect	All staff employed directly by individual, provider or agency including case manager, central office staff	Verbal report within 3 hours reported to Commissioner; Written report within 24 hours;

Department of Social Services (DSS)

Existing system for waivers providing services to persons in the elderly and physical disability target population:

DSS has standard contract language that addresses incident reporting for clients served. This language states as follows:

The Contractor shall submit to the Department's Program Manager an incident report detailing situations that have compromised the health and/or safety of clients served in the program. The incident report shall be submitted within five business days of the occurrence and shall include but not be limited to: client name, staff involved, date, time, details of the incident, an explanation of corrective action taken, and standard operating procedure established to prevent future incidences.

DSS has developed a "Serious Reportable Incident" form presently specific to the ABI Waiver but to be used with Money Follows the Person (MFP). This form has been piloted with an ABI Waiver vendor for the past few months. A Serious Reportable Incident is defined as any situation in which the waiver participant experiences a perceived or actual threat to his/her health and welfare or to their ability to remain in the community.

On contrast, a Sensitive Situation is any one that does not fit within the above categories that needs to be brought to the attention of DSS, within 48 hours of the occurrence, that would potentially threaten the participant's health and welfare or ability to remain in the community, such as an admission into a substance abuse or psychiatric facility.

All members of the participant's care planning team, support staff and service agency staff members are required to report critical incidents. Recipients of Critical Incident reporters include:

- Participant's case manager or social worker depending on the program.
- Cognitive behaviorist (if there is one).
- Participant and/or Conservator.
- DSS Central Office (program manager/social work supervisor).
- DDS Central Office.
- DMHAS Central Office.

Reporting Methods and Timeframes

The provider, pursuant to the “Serious Reportable Incident” form, shall immediately notify DSS by telephone under any of the following circumstances:

- The major unusual incident requires notification of a law enforcement agency.
- The major unusual incident requires notification of child protective services.
- The major unusual incident requires notification of elderly protective services.
- The provider has received inquiries from the media regarding a major unusual incident that has not been previously reported.
- The major unusual incident raises immediate concerns regarding the individual's health and safety such that more immediate notification regarding the incident is necessary.
- The Office of Protection and Advocacy.

The form requires providers to submit a written incident report to the DSS by 5:00 pm the next business day following the provider's initial knowledge of any major unusual incident. By 5:00 pm on the business day immediately following receipt of the written incident report submitted by the provider, DSS shall enter preliminary information regarding the incident through its online system.

Response to Serious Events

All State departments involved with HCBS waivers initiate investigations of any serious issues. Other parties are contacted and interviewed as appropriate. If a concern were raised about any matter that has come up while the consumer was under the support of a provider, the provider would be required to submit an incident report. The specific manner of follow-up for such concerns is determined by the nature of the allegation and the results of the investigation. Possible actions include the suspension or removal of a provider from the active registry/approved provider list or reporting to law enforcement or licensure agencies (e.g., Department of Public Health). Action to ensure the safety of a participant who is at imminent risk occurs immediately (removal of provider and replacement with equivalent service provider). Additional follow-up with other entities include but are not limited to DSS units/divisions (e.g., Quality Assurance, Medical Policy, Legal), law enforcement, Department of Public Health may be necessary. Data from this system will be evaluated with information from the MFP emergency back up plan to assure coordination through the quality improvement committee.

When a participant is age 60 or older and it is deemed appropriate to contact Protective Services for the Elderly (PSE) as part of the investigation, the social worker or case manager depending on the program will assure this is done. In addition, police are notified if any criminal action occurs. Any party involved in the investigation process may initiate contact with PSE or the police. All contacts with PSE and/or the police must be documented as part of the investigation process. PSE Statute 17b-450 – 461 provides the framework for the investigation of abuse or neglect.

The timeframes for response and investigation commencement will mirror the PSE program, which is as follows:

Priority	Response Time
Imminent	Immediate
Emergency	Same Business Day
Severe	Next Business Day
Non-Severe	Within Seven Working Days

DDS Procedure for Critical Incident Reporting

Abuse/Neglect Reporting: Who Reports (Policy No. I.F.PO.001: Policy Statement)

Any employee of DDS or a Provider Agency must immediately intervene on the individual's behalf in any abuse/neglect situation and shall immediately report the incident.

Time-frame for reporting (Procedure Nos. I.F.PR.001 D.2:Reporting and Notification; and PR.001a D.3; PR.005 D.: Implementation)

A verbal report must be made immediately to the appropriate agency (OPA, DCF, DSS) and a subsequent written report by the individual witnessing the abuse/neglect incident. The verbal report is transcribed by the receiving agency and is forwarded to DDS Division of Investigations via fax or secure electronic transmission.

Supervisors must notify State Police in cases involving observed/suspected assault or sexual abuse cases in DDS operated facilities or local police in similar cases involving private agencies.

Regional Directors/Private Agency Administrators must ensure the Regional Abuse/Neglect Liaison is notified within 72 hours of the incident.

Critical Incident Types (Who Reports, Timeframe for Reporting)

Critical Incident Types (Procedure No. I.D.PR.009 C. Definitions) in DDS or Private Agency Operated Settings:

1. Deaths
2. Severe Injury
3. Vehicle accident involving moderate or severe injury
4. Missing Person
5. Fire requiring emergency response and/or involving a severe injury
6. Police Arrest
7. Victim of Aggravated Assault or Forcible Rape

Who Reports (Procedure No. I.D.PR.009 B.: Applicability)

Staff of all DDS-operated, funded or licensed facilities and programs.

Timeframe for Reporting (Procedure No. I.D.PR.009 D.1.a-b Implementation)

During Normal Business Hours: Immediately report the incident to the individual's family and/or guardian and appropriate DDS regional director or designee via telephone. An Incident Report form shall be faxed to the DDS Regional Director's Office. The form should be forwarded to the appropriate DDS Region in the usual process within five business days.

After Normal Business Hours: Immediately report the incident to the individual's family and/or guardian and appropriate DDS on-call manager. An Incident Report form shall be faxed to the DDS on-call manager the next business day. The form should be forwarded to the appropriate DDS Region in the usual process within five business days.

Critical Incident Types (Procedure No. I.D.PR.009a C. Definitions) If Service is in individual's own or family home, and receives DDS-funded services:

1. Deaths
2. Use of restraint
3. Severe Injury
4. Fire requiring emergency response and/or involving a severe injury
5. Hospital admission
6. Missing Person
7. Police Arrest
8. Victim of theft or larceny
9. Victim of Aggravated Assault or Forcible Rape
10. Vehicle accident involving moderate or severe injury.

Who Reports (Procedure No. I.D.PR.009a B: Applicability)

Applies to all staff employed directly by the individual, individual's family or provider agency to provide services and supports to the applicable individuals.

Time Frames for Reporting (Procedure No. I.D.PR.009a D. Implementation)

Immediately notify the individual's family and the individual's DDS case manager or broker. If not available, leave a voice mail message regarding the incident. Complete an Incident Report form. Send or bring the completed form to the employer (individual, family or private agency) who shall keep the original and send the remaining copies to the DDS Regional Director or designee's office immediately or the next working day following the incident.

Situations of exploitation are reported as a Special Concern using the same form and procedure as Abuse /Neglect reporting.

Non-critical incidents are recorded on the DDS Form 255 and submitted to DDS within five business days for entry into CAMRIS. Non-critical incidents include restraint, injury, unusual behavioral incidents and medication errors.

DMHAS Procedure for Reporting

The reporting and review of critical incidents will be an important component of the ongoing evaluation and improvement of the quality of care and services provided by the Department of Mental Health and Addiction Services (DMHAS)-operated and funded agencies and programs. The Health Care Systems (HCS) unit will be responsible for the coordination of this process. Critical incidents, as defined by DMHAS Commissioner's Policy Statement No.81, are incidents that may have a serious impact on service recipients (including those served under a Medicaid Waiver), staff, funded agencies, or the public, or may bring about adverse publicity.

All critical incidents will be reported to the DMHAS Office of the Commissioner. Such reporting will be the responsibility of the Chief Executive Officer (CEO), or designee, of the State Hospital, Local Mental Health Authority (LMHA), Private Non-profit Mental Health Agency, or Substance Abuse Treatment Agency, (hereinafter called "facilities").

When a facility becomes aware of a critical incident, verbal notification will be required to be provided within three hours to the Office of the Commissioner's Critical Incident Report Line at 860-418-8750. This line will be staffed during normal business days/hours. After normal hours or as directed by the Critical Incident Report Line, a verbal report can be made by calling the switchboard at Connecticut Valley Hospital at 860-262-5000 and requesting that the Switchboard contact the On-call Health Care Systems (HCS) Manager. A written report is required within one business day to the HCS Confidential Fax at 860-418-6730.

Once HCS staff receive the critical incident reports, they will clarify information, enter the data into a dedicated data-base for critical incidents and distribute reports of each incident to the DMHAS officials responsible for oversight of quality, contract compliance, safety and administration.

Critical incident follow-up reviews will be conducted by the reporting agency within 30 days of the incident. This review will focus on causative factors and may result in the development of a corrective action plan designed to reduce risk of reoccurrence of similar events. Written accounts of these reviews will be faxed to HCS, checked for completeness and entered into the critical incident database.

Abuse and Neglect

For people between the ages of 22 through 60 years, abuse and neglect will be reported using the critical incident process. Critical incidents, as defined by DMHAS Commissioner's Policy Statement No.81, are incidents that may have a serious or potentially serious impact on DMHAS clients, staff, funded agencies or the public, or may bring about adverse publicity.

For persons aged 60 or older, Section 17b-451 of the Connecticut General Statutes will require medical professionals, social workers, police officers, clergy, and nursing home staff to report to the DSS any knowledge or suspicion of abuse, neglect, exploitation, or abandonment. In addition, friends, neighbors, family members, and acquaintances who suspect an elderly person are being abused, neglected, or exploited may call the closest office of the DSS.

In addition, there will be an electronic on-line process available to the people enrolled in the waiver and their families to report abuse, neglect, and exploitation.

Appendix N: Housing Inventory

Housing Inventory

Community Housing Options

A range of housing options with long-term care supports is available in Connecticut, affording individuals who have long-term care needs the ability to avoid entering into an institution.

Housing Type	Facilities	Units	Residents	Age
Congregate Housing 2005	23	Varied	951	62 and older
Assisted Living 2006	109	6,900	Varied	Adults and elders
Residential Care Homes 2006	102	2,826	2,593	Adults and elders
CCRCs 2006	17	3,200	Varied	Elders
Nursing Facilities 2006	246	29,540 Beds	27,575	All ages

Congregate Housing provides frail elders with private living arrangements, moderate supportive services as well as common areas for dining, socialization and other activities.

Connecticut's MFP Demonstration

Assisted Living Services/Managed Residential Communities offer an attractive residential alternative to seniors age 55 and older who do not require the intensive care provided in nursing facilities. In Connecticut, assisted living service agencies (ALSAs) are licensed to provide assisted living services in managed residential communities (MRC). Collaborative interagency efforts have resulted in expanding the assisted living services to lower-income individuals. In the "Assisted Living Demonstration Project", four subsidized pilots were approved by the General Assembly in 2001. Medicaid coverage for assisted living services has also been extended to State-funded congregate housing, federally financed HUD complexes and a pilot for up to 75 people who reside in private pay assisted living facilities.

Residential Care Homes (RCH) provide a room, meals and supervision for individuals whose limitations prevent them from living alone and do not require nursing services.

DMR group homes are licensed facilities which include group homes, community training homes and community living arrangements for individuals whose limitations require assistance.

Continuing Care Retirement Communities (CCRC) offer lifetime living accommodations and a wide variety of services, including a specified package of long-term health and nursing services for older adults. People usually enter these living arrangements while living independently, but are able to receive services at any level of care required as they age.

Supportive Housing in Connecticut is a Supportive Housing Demonstration Program that provides affordable, independent housing with a social service component for tenants who

require such services. Supportive housing tenants choose to live in the housing, hold the lease and cannot be evicted for non-compliance with social services treatment plans. Approximately 70% of the units are reserved for individuals who were formerly homeless or at risk for becoming homeless; 50 % are reserved for people with HIV/AIDS, mental illness, or chronic substance abuse.

Residential Settings for Individuals with Psychiatric Disabilities: The Department of Mental Health and Addiction Services (DMHAS) funds several types of 24-hour, seven day/week residential settings for individuals 18 and older, including group homes, supervised housing, long-term treatment, long term care and transitional care halfway houses.

Appendix O: Case Studies

Transition of Elder Population

Mrs. Jones is an 83 year old woman who has been living in a skilled nursing facility since February 2005. Until Mrs. Jones moved to the nursing facility, she lived independently in her home where she and her husband had raised their three children. She and her husband had promised each other that they would stay in their home and take care of each other as they got older. Nursing homes would not be an option for them.

Circumstances changed for Mrs. Jones when her husband died suddenly in 2001. Mrs. Jones was left with all of the work involved in maintaining the family home that she and her husband had worked so hard to build. Only one of Mrs. Jones' children lived in the same town, her daughter Susan. Susan and her family helped Mrs. Jones with the lawn in the summer and the snow in the winter. Despite the extra responsibilities at home, Mrs. Jones continued to actively participate in her church. Every Sunday morning, a member of the congregation would stop by Mrs. Jones' home and take her to worship.

Mrs. Jones had fallen twice during the fall of 2004. One of the falls just led to some bruises. The other resulted in broken ribs. Each time Mrs. Jones returned home after brief visits to the emergency room. After the last fall, Susan had taken time off of work to help Mrs. Jones with personal care for a few days. Susan was concerned about Mrs. Jones living alone and discussed these concerns with her mother. Despite her daughter's concerns, Mrs. Jones had no plans to leave the family home.

On Sunday morning, December 12, 2004, Mrs. Jones was getting ready for church as she did every Sunday morning. She watched for her ride from the window in the living room of her home. When she saw the car arrive, she hurried down the driveway so that the driver would not have to wait. She never made it to the car. She slipped and fell on black ice leaving her with a broken hip.

She was hospitalized for a week following the fall. The plan for discharge included six weeks of rehabilitation at the local nursing home. Mrs. Jones was agreeable to the nursing home as a short term solution.

Complications increased at the nursing home. Mrs. Jones experienced a number of infections which increased the time anticipated for rehabilitation. At the end of three months, Mrs. Jones was still not permitted to walk without assistance from staff. She spent most of her day in a wheelchair. At the end of four months, the nursing home discontinued physical therapy because the facility felt she no longer benefited from physical therapy. Mrs. Jones still wanted to go home.

Mrs. Jones' daughter reasoned that her mother could not return home without 24-hour assistance. While the nursing facility staff agreed, Mrs. Jones did not. The bills from the family home continued to mount. The likelihood of Mrs. Jones returning home to live continued to diminish. An important decision had to be made. It was Susan who took the lead and counseled her mother to accept the reality that going home was not an option. With her relationship to Susan in the balance and the bills escalating, Mrs. Jones agreed to sell the family home. It was agreed that

she would spend down so that Medicaid would pay for the care that she could no longer afford. Mrs. Jones struggled with the loss of independence. She felt she would never have the choice to live in the community again.

Susan read about Money Follows the Person Rebalancing Demonstration in the newspapers. The newspaper made it clear that 24-hour care at home would be an option for people who were living in nursing homes. Based on the availability of 24-hour care, Susan called the MFP Demonstration office number in the newspaper to request additional information. Later that day, Susan went to visit her mother. She took the newspaper article with her and showed it to her mom. Mrs. Jones mentioned that she had recently received a letter from the DSS announcing an upcoming meeting at the facility. The meeting would provide an opportunity to learn about the demonstration and ask questions. Mrs. Jones and Susan decided to attend the meeting.

On March 30 at the on-site meeting, Mrs. Jones, her daughter and several other residents of the nursing home met Rick, the transition coordinator for the first time. Rick told them about the demonstration and some of the new services available for people who wanted to live in the community. There were many questions about 24-hour assistance. Rick made it clear that 24-hour assistance was based on the individual care needs of the person. Rick also told them about a new service delivery model called self-direction. In addition, he mentioned that the demonstration provided assistance for finding and/or affording a home and talked about participants' rights and responsibilities under the program.

Rick had information packets about the demonstration available for residents who were interested in applying. He briefly reviewed the contents which included the application and a brief program overview. He described the application process which included a lottery system. He told them he would be available to go over the information in more detail or assist with the application process if they felt it would be helpful.

Mrs. Jones and Susan returned to Mrs. Jones' room that day very excited. They completed the application within the hour. The application was in the mail by 5:00 PM.

About a month later, on April 2, 2008, Mrs. Jones received a letter and package of materials from the DSS MFP program office confirming her eligibility for the MFP demonstration and assigning her a transition number. The package of materials included a guide to the transition process, a self assessment tool, a guide to rights and responsibilities under MFP. The letter also indicated that she had been assigned a transition number '12' which meant that she should expect a call from the transition coordinator assigned to her case within the next three days. The very next day, Rick called Mrs. Jones to set up a time to meet with her so that they could get started. Mrs. Jones knew that Susan would want to be there for the first meeting so they set up the meeting for April 12, a Saturday morning. Rick encouraged Mrs. Jones to review all of the materials and complete the self-assessment. Mrs. Jones and Susan enjoyed completing the self-assessment.

At the first meeting, Rick learned many of the details which led to Mrs. Jones moving to the nursing home. He learned about her former involvement in the church and community and he learned about the close relationship she shares with her daughter. Together they reviewed her

completed self-assessment. Rick asked questions to better understand why she felt she did or did not need certain services.

Mrs. Jones was very concerned about the fact that she had no money. 'Where would she live?' Rick explained how Medicaid works a little differently in the community and suggested that together they would work on a budget. After taking the time to address Mrs. Jones' concerns, Rick reviewed the informed consent paperwork and releases that Mrs. Jones was required to sign for participation. Mrs. Jones felt comfortable and signed all required documentation. Rick left that day explaining to Mrs. Jones that he would be back the next week. He told her it was most important for her to gather personal documents such as her birth certificate and her Social Security card.

Rick returned the next week and Mrs. Jones already had all of her documents together. Rick continued the meeting by discussing housing options. He told Mrs. Jones that she could move to an assisted living unit or to an apartment. Mrs. Jones noted that she would prefer a home as close as possible to her church with a kitchen. Rick told Mrs. Jones that he would forward her request to the housing coordinators. He also asked if she had any friends at the church who may like to help plan her move back to the community. Mrs. Jones said she would invite some friends to the next meeting. In the interim, Rick told Mrs. Jones that a social worker from Connecticut Community Care Incorporated (CCCI) would be scheduling an appointment within the next three days to assess Mrs. Jones' level of need for community services. Before leaving that day, Rick had Mrs. Jones complete the paperwork for rental assistance.

Mrs. Jones' assessment was completed the following week on April 24 and Mrs. Jones was found to be eligible for the Home Care Program for Elders waiver. Mrs. Jones' individual budget for services was set. She was offered the choice of having CCCI assist with selecting services and providing case management for her or of selecting a fiscal intermediary who would counsel her on budget development so that she or her representative such as her daughter, Susan, could self direct. Mrs. Jones decided along with her daughter that they would select the self-direction model. CCCI assured them that if at any time they no longer wanted to self-direct, the option for an agency directed model would remain open. Susan expressed concerns that her mother was not offered 24-hour care. CCCI reviewed Mrs. Jones risk profile and discussed with both Mrs. Jones and Susan how there were some risks but that they were minimal given the range of services. 24-hour care was designed for people who need 'hands on care' 24-hours a day. Mrs. Jones did not need 24 hours of hands on care. Susan admitted that her mother did not need 24 hours of hands on care, but that her concern was about what would happen if her mother fell. They were reminded that it is impossible to remove all risk from life. People fall even with 24-hour care and people fall in nursing homes. Susan and Mrs. Jones agreed and decided to move ahead with developing the care plan within the budget allowance. Once it was completed, they would submit it to CCCI.

The next meeting on May 20 involved not only CCCI staff but also Rick, the transition coordinator, Mrs. Jones' friend, and Susan. The housing coordinator had identified apartments meeting Mrs. Jones criteria and forwarded this information to Rick. Locating an apartment was much quicker than in the past since Connecticut now has a housing registry to keep an inventory, housing coordinators to continually locate new housing, and housing subsidies that make

apartments other than subsidized housing possible. They scheduled the next meeting on May 27 to go see the apartments.

Mrs. Jones loved one of the apartments and a discharge date was set for July 1. The next month was busy as Susan and Mrs. Jones with assistance from Rick, identified personal care support and back up. Rick had Mrs. Jones begin to think about furniture needs. Based on the fact that Mrs. Jones had minimal personal belongings, Rick established a budget of \$400 to cover apartment set up costs such as furniture.

The week before the move was busy. Utilities were turned on, the phone was hooked up, and furniture arrived. Arrangements for medication were carefully tended to so that Mrs. Jones would have enough medication until her first doctor appointment in the community. Rick assisted Mrs. Jones in identifying a doctor in the community and in setting up the first appointment before leaving the nursing home. Rick also carefully explained the triage back up support system for the demonstration. Mrs. Jones noted that she had an emergency back up plan in her care plan. Rick explained that the demonstration 24-hour triage back up system was put in place as a last resort in the event that personal care plan back up systems did not work for any reason. He explained that someone would be available 24/7 to help her.

The day of the move arrived and Rick accompanied Mrs. Jones and Susan to the apartment to make sure that all of the details were in place. Rick left feeling that everything had gone well, explaining that he would be back to visit in a week. Mrs. Jones settled into her new home.

The first three weeks everything went very well. Then, on July 25, Susan's father-in-law had emergency surgery and her family flew to San Diego to help out. At the same time, Mrs. Jones' best friend was diagnosed with the flu. These people represented Mrs. Jones' back up plan so when her staff called in sick one morning, Mrs. Jones was left in bed with no assistance. Mrs. Jones used the 24-hour emergency back up number that she had been given for the demonstration. The nice woman on the phone had the back up coordinator call Mrs. Jones within five minutes. The back-up coordinator determined that this situation warranted support from demonstration emergency back up staff. Back up staff was at Mrs. Jones' apartment within two hours.

When Mrs. Jones completed her consumer satisfaction survey at the three month interval, she indicated that she was much happier than in the nursing home, had about the right amount of company, got out to church once a week, and felt that she had a great deal of choice and control over her services and home. Things appeared to be going well. Over the next few months there was no need to use the emergency triage system and Mrs. Jones was enjoying her own home again.

On December 4, Rick stopped in to see Mrs. Jones. This was scheduled as Rick's last visit. Mrs. Jones was confused when Rick arrived. She did not seem to recognize him and was confused in general about where she was. Rick suggested that she call 911. Mrs. Jones did not feel that was necessary. But, Rick noticed that Mrs. Jones was slurring her speech. Rick's concerns for the situation, translated into a 911 call. Mrs. Jones had many of the warning signs of a stroke.

The hospital confirmed the stroke. Mrs. Jones was admitted and cared for in the hospital for ten days. The stroke resulted in some paralysis to her left side and some difficulty with speech. It was recommended that she return to the nursing facility for rehabilitation.

On December 15, Mrs. Jones was admitted to the nursing facility. She was expected to be there for at least three weeks. Concerns regarding her apartment and personal assistants were increasing. Susan had paid for the personal assistants during her hospital stay. Mrs. Jones loved her staff. Susan wanted to assure that they would not take other jobs during her mother's rehabilitation. Mrs. Jones income was diverted to help pay for the rent and the state continued to pay the rental assistance portion during the next few weeks. When January 4 arrived, Mrs. Jones was disenrolled from MFP HCBS services. Rick comforted Mrs. Jones by telling her that he would help her return to the apartment as soon as she was strong enough. On January 18, Susan called Rick and told him that she felt her mother was strong enough to return home. Rick asked CCCI to visit Mrs. Jones and reassess her level of care to assure that the care plan originally developed was still adequate. A new care plan was developed with additional hours for hands-on-care.

Mrs. Jones could not wait to return to her apartment. Fortunately, that day arrived on January 23. Mrs. Jones returned to her apartment with MFP services. At the end of the first year in the community, CCCI revisited Mrs. Jones as they had several times during the year for her annual assessment. During the annual assessment, Mrs. Jones was reminded that she was no longer in the demonstration but that she was now formally enrolled in the Home Care Program for Elders waiver. The only difference to Mrs. Jones was in the paperwork. Her services were not affected.

Transition of Intellectually Disabled Population

Sam was moved to the nursing facility on June 3, 2001. He was 36 at the time. They said it would just be for a few days. He did not want to go. He wanted to go back home with his Dad. Actually, he wanted to go to his own place. He had always planned on having his own place. But, it had never happened. Mom had always said he needed to have a job first. But Mom died just before he graduated from high school 15 years ago. And, when he got his first job, he still did not get his own place. It had not happened the way she always said it would.

Sam's move to the nursing home was not planned at all. After his Mom died, Sam continued to live with his Dad in West Hartford. Things were going fairly well. Sam's Dad helped Sam regulate his diabetes even though Sam did not think he needed the help and Sam helped his Dad with the household chores. Everyday, Sam took the bus to work at the local grocery store where he worked 20 hours a week. Sam loved his job and everyone loved Sam. Sam and his Dad never talked about Sam getting an apartment the way his Mom had. They actually never talked about anything other than dinner, chores and the Yankees. Sam's Dad liked having Sam at home.

The situation changed suddenly on May 25, 2001. It was on that day that Sam's father became ill and was hospitalized. Sam was at work when the ambulance arrived at the house. When Sam arrived home, a neighbor stopped by to tell him that his Dad was in the hospital. Sam went with

the neighbor later that night to visit his Dad. That was when Sam learned for the first time that his Dad may not be coming home for a while. Sam was on his own for the first time.

Sam liked being alone and everything went fairly well for the first week. He got to eat whatever he wanted in his bedroom, not at the dinner table. When he ran out of clean dishes, he just used the dirty ones over again. He did not have to brush his teeth and he did not have to take a shower. He did not even have to take his insulin. When he ran out of groceries, he bought more at the store where he worked. No one there said anything about what he bought: soda, pretzels, milk, cheese and bread.

On June 3, the trouble started. Sam woke up not feeling well but still knowing that he had to go to work. Going to work was the rule. As he walked across the yard to the bus waiting at the end of the street his decision to no longer take his insulin caught up with him. He never made it to the bus. A neighbor found him on the ground and called 911. Sam woke up hours later in the emergency room surrounded by strangers. They explained that he had become hypoglycemic and asked questions about his diabetes and about who was taking care of him. Sam explained about his diabetes and about how he could take care of himself. But, no one could understand his speech. While Sam wanted them to see the independent man that he was, all they saw was a 36 year old male with Down Syndrome who had a severe intellectual disability, diabetes and severe apraxia. Sam did not really have a severe intellectual disability but people always thought that at first since he had such trouble communicating. With significant concerns regarding judgment and maintenance of chronic illness, a call was made to the Department of Developmental Services (DDS). After some difficulty finding Sam's Dad, they finally located him in XYZ nursing home where he had been transferred after his hospitalization. Given the options, Sam's Dad wanted Sam to come live at the nursing home with him.

Some six years had passed since that day. Sam's Dad has since passed away. Sam's brother in San Diego agreed to be Sam's limited guardian for residence and medical issues. Sam spent most of his days at the nursing home in front of a television. The staff had become his only friends and he missed his job in West Hartford. While Sam struggled to be understood when he first arrived, most of the staff now could understand a few words. If nothing else, they knew he loved the Yankees.

Sam's social worker at the nursing home was named Anne. In January of 2007, Anne saw a press release about the state's Money Follows the Person Demonstration. She then attended a workshop about MFP at the Connecticut's National Association of Social Workers Annual Conference. She called the DSS Central Office asking for additional information and mentioned that she knew someone whom she felt would be appropriate for the demonstration.

It was early in the month of March when Anne learned about the informational meeting scheduled at the nursing facility where she worked. She went to Sam and told him about the meeting. They agreed to go together.

Sam decided that he liked Claudia, the transition coordinator who was running the informational meeting on March 20. Claudia explained what the demonstration involved and the responsibilities of participants. She told him about the rules for getting accepted into the

demonstration and asked if his name was on the DDS “Olmstead list”. Sam replied that his name was on the list and Anne confirmed that it was true. What Sam understood from the meeting is that he could probably have a job and his own place, just like his Mom had said he could. Sam took the packet of information Claudia gave to him and asked Anne to help him with it.

Anne helped Sam complete the application. They both decided to use Anne’s phone number as a contact since Sam had trouble talking on the phone. By March 25, the application was in the mail. About a month later, Sam received a letter from the DSS confirming his eligibility in the MFP demonstration. The letter noted that his transition number was ‘5’ and that a transition coordinator should be contacting him within three days. The letter was accompanied by a transition guide, a self-assessment tool and a description of Sam’s rights and responsibilities as a MFP participant. Sam asked Anne to help him with the materials and with completing the forms so that he would be ready when his transition coordinator called. They did not have to wait long for a phone call. On April 28, Claudia called Anne asking if she could talk to Sam about a good time for a visit. Sam and Anne had already discussed that if Claudia ever called, Sam wanted to see her as soon as possible. Anne indicated this to Claudia and a meeting was set up for May 2.

Anne was in Sam’s room when Claudia arrived. Together they reviewed Sam’s self-assessment. Claudia was surprised that Sam did not feel he needed help with anything. She mentioned that everyone needs some help. They talked about how Sam came to live in the nursing home and Claudia learned about Sam’s mom and dad. She also learned about Sam’s love for the Yankees and Sam’s old job at the grocery store. Finally, Sam talked about the night that his former neighbor called 911. Claudia looked to Anne to understand Sam as he talked. She could not understand his speech at all.

Claudia told Sam that his brother in San Diego would have to agree for Sam to participate in MFP. Sam objected but Claudia explained the rules. Claudia also explained Sam’s rights and responsibilities under the demonstration once again. While Sam would have some help, it was really important for Claudia to know that Sam understood how to use the emergency back up number appropriately. While Sam said he understood the information, Claudia was sure they would have to review this again before Sam moved. Sam signed his letter of interest which Claudia copied and sent to his brother along with a letter explaining the MFP Demonstration Project.

On May 22, Claudia called Sam’s brother in San Diego to follow up on the letter. He confirmed that he had received the letter but unfortunately did not feel that the program was appropriate for Sam. Claudia mentioned how many people with more severe disabilities than Sam were living happily as part of the community. She went on to explain the quality assurance mechanism in the community and that she could tell Sam how much wanted to move. While Claudia was generally successful with guardians, she was not successful with Sam’s brother. He did not want Sam to move to the community.

The next meeting with Sam and Anne was scheduled for May 29. Claudia was concerned about sharing this news with Sam. She knew how disappointed he would be. She decided to talk to Anne first. Anne was notably upset by the news. She had known Sam from the day he had first moved to the nursing home and had grown quite fond of him. Despite how much she would

miss him, she wanted Sam to move to the community. She knew how much he wanted to live on his own in the community with a job. Anne discussed the possibility of becoming Sam's limited guardian rather than his brother. Claudia explained that there were two ways this could happen. 1) They could explain to Sam's brother that Anne was interested in assuming the responsibility and see if he agreed. 2) If he did not agree, they could request a status hearing and request to have him removed as guardian based on the fact that due to living in California he has not been able to attend any of Sam's meetings and he has been difficult to contact as his job requires frequent and lengthy travel. Clearly the second option would not be easy.

Anne and Claudia went together to explain the situation to Sam. Sam liked the idea of Anne being his guardian. He wanted them to call his brother. A phone call was made the following day to Sam's brother. Claudia, Sam and Anne were all on the phone. Anne talked to Sam's brother about how fond she was of Sam and how much he wanted to live in the community. She then mentioned that she would be willing to serve as guardian, assuming responsibility for Sam in the community if Sam's brother would allow it. Sam's brother agreed since he was unable to travel to Connecticut as often as he used to and felt that someone who lived closer could be more involved in developing Sam's support plan. He asked to be kept informed of important events in Sam's life and planned to visit Sam once he was settled in his new home. Paperwork was filed with the court on June 3 to change guardianship.

Transition plans continued on June 7 while they waited for the final paperwork appointing Anne guardian. It was explained that Anne would have to be appointed guardian and sign informed consent prior to Sam moving. Claudia mentioned that Sam would need to find his birth certificate and social security card. Sam did not know where they were. Claudia said she would help him get duplicates and that they had to start this process right away because sometimes it takes a long time.

The third meeting with Claudia was the most exciting one for Sam. They talked about where Sam would like to live and work. They also talked about friends that Sam used to have at the grocery store. Sam was sure they were all still there. Claudia was not so certain. Sam wanted to move back to West Hartford and work in his old job with his old friends. Claudia left that day telling Sam that she would try to find a place for him to live and that his next visit would be from a case manager at the DDS. DDS would determine his level of need for support in the community.

The case manager arrived on June 15 and asked Sam lots of questions. Sam did not know the answer to some of the questions. Anne stopped by and helped answer some of the more difficult questions. When the interview was over, the case manager talked to Anne and Sam about self-directing and individual budgets. She explained that Sam had a choice of hiring his own staff, hiring an agency that would help him hire staff, or just having one of the DDS approved agencies arrange his supports in the community. Sam wanted to do everything himself. The case manager told Sam that was called self-directing. She went on to explain that Sam's 'level of need' would be determined based on his answers to the questions she had just asked. The level of need would then be translated into a personal budget. Then, Sam and Anne could work together to develop an individual plan. They could get help from a support broker. The support broker could be someone who works for DDS or someone else they wanted to choose as long as

the person met the qualifications. The qualifications were all written on a piece of paper that the case manager had given Sam. Sam decided that he wanted to choose his own support broker. He was told that he could use money from his support budget to pay for the broker services.

Sam received a call from DDS letting him know that his budget for community supports had been established at \$36,000. He called the independent broker with Anne's help and set up a time for the broker to visit Sam in the nursing home. The broker's name was Molly. Sam liked her. She took the time to try to understand what he was saying. Molly explained that she would help Sam decide what services he needed and even help with finding staff if he wanted her to. Molly also explained that there was something called assistive technology that was like a computer Sam could use to help him communicate with other people. That way, the next time he went to McDonalds, he could order his food himself. Sam liked that idea. By the end of the meeting, they had drafted a budget for Sam that included among other things, staff support, transportation and assistive technology. They sent the plan to the DDS case manager for approval.

On August 3, the Probate Court hearing was held to change guardianship for Sam. Claudia coordinated a meeting immediately following the hearing with all of the people helping Sam. Anne was now permitted to sign the informed consent for Sam to move to the community. The paperwork was signed. Everyone offered status updates on Sam's transition plan. Molly reported that she had already found a few people for Sam to interview that could help him at home. Sam showed Claudia the Social Security card and birth certificate that had arrived. Claudia also mentioned that the housing coordinator had found an apartment that they thought Sam could afford and may like close to a bus line in West Hartford. The paperwork for rental assistance was completed. A visit was scheduled following the meeting so that Sam and Anne could go look at the apartment. Claudia mentioned that they could also stop and visit the grocery store where Sam once worked.

On August 10, Sam went to see the new apartment. From there he went to the grocery store, where he hoped to see his old friends. When he walked through the door of the grocery store, he was immediately recognized by Mr. Radzins, the store manager. By the end of the brief conversation, Mr. Radzins was asking when Sam was coming back to work. Sam left very happy and eager to move to his own apartment.

The next team meeting was held on August 17. The team members were all present and all documents and paperwork had been received and approved. Claudia explained that the landlord was anxious to rent the apartment beginning September 1. Claudia asked Sam if he had found staff to help him and he reported that he had. He showed her the names of the people and told her that they all liked the Yankees. Claudia asked Sam and Molly if the home health agency had been contacted to support Sam with his diabetes management. Molly reported that the nursing was all set up. Claudia asked Sam what he thought he needed in order to move on September 1. Sam responded that he needed food and a bed. Claudia asked if he thought he would need a place to put his clothes and a place for people to sit when they visit. Together, they created a list. Claudia told Sam that based on the list he would have a budget of \$1,000 from MFP to purchase what he needed.

The following week Anne took Sam shopping. They found furniture and a few other things for the apartment and made arrangements for delivery on September 1. While they were out, they stopped at the New England Assistive Technology (NEAT) marketplace in Hartford. Claudia had set up a meeting for them there so that they could see some of the computers that are available to help people communicate. Sam tried lots of different computers then he chose the one he liked best. The people at NEAT said that he could borrow it for a month to make sure that it would work for him. Sam and Anne left that day with the computer. To help Sam learn how to use the computer, Claudia coordinated the rental with the State's Assistive Technology Peer Assistance program which offers training support from persons who have had success using similar computers.

The discharge date approached quickly. Claudia helped Sam set up appointments with his old family doctor and with Mr. Radzins at the grocery store. They checked to make sure that he had enough medicine to last until he visited his doctor and they started to pack his suitcase.

Sam was ready to go early on September 1. The ride to the apartment was filled with anticipation. On the way, they decided to stop for a few groceries. The day at the apartment was busy. Furniture arrived and around dinner time, Sam's first support staff person arrived. Sam also had visits from the home health agency nurse and the landlord. With Anne there, Sam signed a timesheet for the first time. Everything went as planned.

Two weeks later, Sam took the bus alone for the first time from his apartment to the grocery store. Sam took his new computer with him in case he needed it. Sam was the proudest looking person getting off the bus that day at the grocery store. Mr. Radzins asked Sam if he was ready to work and Sam reported yes. Mr. Radzins said they would need to set up a schedule. Before Sam left that day, he had his schedule for work.

Claudia checked in with Sam several times over those first few weeks. Sam was lucky because everyone loved working for him. Anne and Sam decided to buy the computer that helped Sam communicate. The cost was already included in his budget. By the time Sam participated in his first consumer satisfaction survey, he reported that he loved everything. He loved having Anne visit, he loved his staff, he loved his job and he loved his apartment. Now that he had his own place and a job, he planned on finding a wife.

During the first year, Sam had quarterly contact from his case manager to reassess his needs and assure that risks for Sam in the community were addressed. Anne was present each time and special attention was given to how Sam's plan addressed potential areas of concern. Sam did not see the risks as everyone else did. Sam loved everything about his new life and felt very safe on his own. At the end of the demonstration year, services continued under the DDS Individual and Family Support Waiver with no apparent change to Sam.

Transition of ABI Population

In 2004 at age 28, Bill was working for his father in his carpet laying business and part time as a stock clerk at Target. This was not the first time that Bill had worked for his father over the past few years. Bill hated the work and the thought that once again he was dependent on his father. But he just could not seem to find that one thing that he really enjoyed doing long enough to stick with it. He did not have any money in savings and he needed to pay his rent, so once again it was back to his father's store. This seemed to be a cycle that Bill could not break.

While laying carpet in a church basement, he suddenly became violently ill and was admitted to the intensive care ward of a local hospital. After hours of testing, his condition continued to worsen and he was diagnosed with multi-organ failure. His problems included intracerebral hemorrhage, aspiration pneumonia, respiratory failure, sepsis, infections at multiple sites, acute renal failure, and hepatitis. The cause could not be identified, but he sustained severe hypoxic brain damage.

Bill remained in the hospital for more than two months. While he had been medically stable for some time, he had limited control of his limbs and trunk. His long-term prognosis for neurological recovery was not good. He also had uncontrollable seizures. His healthcare team was working to determine a drug regimen that would minimize both the frequency and the intensity of the seizures. Bill was referred to an ABI rehabilitation program for more intensive treatment and follow-up for his condition.

A year and ½ after his accident, Bill has regained most of the control of his legs and feet but still has limited control of his hands. He requires assistance with several ADLs and IADLs. He regained all of his memory from prior to the accident but his working memory is that of a 15 year old. Bill's personality also drastically changed. He went from a mild mannered guy to someone that is very volatile. He is easily angered and becomes out of control without any warning and at the slightest provocation.

Following the accident, Bill's family was unable to give him the care that he needed at home. He has been in a nursing facility for more than three years. He hates it there. He feels so out of place. All of the other people around him are sick and very old but he is not. He does not feel that he should be there and yet he understands that it would be very difficult for his parents to take care of him at home. Perhaps things would be better if he was able to make friends but he has a very hard time relating to the people there. 'Many of them cannot even talk!' Bill has one very good friend, Kelly, another young gentleman who is very different from the rest. He is fun and likes a lot of the same things that Bill does, like watching karate movies and playing video games. Kelly and Bill are peers.

One day when they were talking, Kelly shared very sad news with Bill. He, Kelly, would be leaving the nursing home very soon. He had applied for a new program called Money Follows the Person and was accepted. This program had helped Kelly find an apartment. This made Bill very sad. He became very upset, knocking a lamp on the floor and began to stomp out of the room. Kelly was able to calm Bill down. He was one of the very few people that could do this.

Kelly told Bill that if the MFP program could help him get out of the nursing home that it might be able to help Bill as well. Kelly helped Bill call the MFP office to get an application package.

As much as he hated it, Bill had assumed that he would always live in the nursing home. In the beginning he had thought a lot about leaving the nursing home, but as time went on he stopped thinking about it because he felt it was a dream that would never come true, so why waste time and energy thinking about it. Over the next few days he became very agitated thinking about possibly moving out. He would not admit it to anyone but he was afraid. He could not take care of himself, alone, he needed help. Would he have the help that he needed? Where would he live? Would he be able to see his parents when he wanted to? He had so many questions. He had a hard time sleeping and focusing. His behavior was, at times, out of control, he had several time outs in his room.

The application packet arrived by the end of the week. The next day when Bill's parents came to visit, Bill shared the application packet with them. Bill had told them about the program. They also knew about Bill's recent behavior and knew their son well enough to know that his behavior was because he was afraid. They spent a lot of time talking with him and assuring him that no matter what happens, they would make sure that he was o.k.

Bill's parents were very curious to find out more information. They were also cautious. "Could this program really give Bill all the supports he needs to live in the community?" With Bill, they read through all the materials. There were a few things that they needed to get clarification on, such as did they have to pay anything for Bill to participate in the program. Even though the materials did not say this was the case, they wanted to be sure. Could anything this good really be free? They would do anything to help Bill but financially things were not going well for them. Business at the store had been very slow for quite some time. If they needed to come up with additional funding in order for Bill to participate in the program they would do so, but they wanted to know as soon as possible in order to prepare. The office was still open for the day, so they called and were relieved to find out that if Bill was determined eligible for the program there was no cost to participate in the program.

Together Bill and his parents filled out the application. The next few weeks were very hard for Bill. He could not understand why it was taking so long to hear back from the MFP office. This was also the time when his friend, Kelly, was discharged from the nursing home. Kelly invited Bill to visit him in his new apartment but he refused to go. He was angry at Kelly for leaving him all alone. He did not have anyone else to talk to at the nursing home. He spent most of his days after Kelly's discharge in his room watching T.V.

On May, 22, three and ½ weeks after Bill and his parents mailed the application, Bill received a letter from the MFP program office telling him that he was eligible for the program and assigning him a transition number of '20.' The letter stated that the transition coordinator's name was Rick and that he would receive a call within three days. Also included in the packet of materials were a transition guide, a self-assessment tool, and a description of Bill's rights and responsibilities as an MFP participant. Bill did not have to wait long for Rick to call; he called the next day and scheduled an appointment to talk with Bill and his parents the following week.

Bill started filling out the self-assessment form the day Rick called. But there were many things on the form that he did not understand and was not sure how to answer, so he asked his parents for help. They were more than happy to help Bill. Since the accident, this was the first constructive thing that Bill had focused on. They would do anything to help him get out of the nursing home. The nursing home is not where they wanted their son to spend the rest of his life.

The night before the meeting with Rick, Bill did not sleep. He was too excited. The next day, he called his parent's several times to make sure that they would be on time for the meeting. Bill was dressed and ready for the meeting at 7:00am. The meeting was not until 1:30pm. Alan arrived a little early for the meeting. Bill looked at him, studying his face before saying anything. Bill liked Alan right away, he had a friendly face.

Alan talked with Bill and his parents about the program. He shared with them a housing guide, medical release forms and informed consent document. He talked with Bill about the different housing options. He asked Bill what things he liked doing, his dreams and goals. Bill liked that Alan talked to him like he was an adult and directed questions to him and not just his parents. They reviewed the self-assessment that Bill and his parents had completed. Alan also shared with them the 24-hour back-up triage system available to people who participate in the program. Before leaving, Alan told Bill that for their next meeting he would need to gather several personal documents such as his social security card and birth certificate. Alan also asked Bill to sign the informed consent. Based upon this first meeting, Alan knew that the nursing home was not the right environment for Bill but was not sure what was. He sensed that Bill was a very angry young man and lonely man. The second meeting was scheduled for the following week.

For the next meeting Bill made sure that he had all of the information Alan had asked for. Again, Bill's parents participated in the meeting. Bill wanted them to be part of the meetings and they wanted to be there as well. They spent more time talking about the housing options available to Bill. They also talked about the possibility of Bill finding a job or having some involvement in the community once he was in an apartment. Alan explained to Bill what to expect and what would happen next. He felt that it was very important for Bill to understand all the steps in the process. Alan also explained to Bill that a social worker from CCCI would be scheduling an appointment with the next three days to assess Bill's level of need for community services. Alan also worked with Bill on completing the paperwork for rental assistance and for talking with potential job training sites.

As Alan said, the CCCI social worker called and scheduled a meeting for the end of the week. The CCCI social worker completed the assessment and told Bill that he was eligible for the ABI waiver. The CCCI social worker told Bill that he had the option to self-direct his care. He did not really know what this meant, but after it was explained to him he thought it was great. Bill chose to select a fiscal intermediary who would help counsel him on developing a budget.

A third meeting was scheduled for the next week. Alan and the CCCI social worker both participated in this meeting. Bill's parents were also there, once again. Alan had reservations about Bill living alone. But he also was not sure how well he would do with roommates. He wanted to try to use this meeting as an opportunity to try to figure out the best option for Bill. Alan remembered that during their first meeting Bill had mentioned his friend Kelly. Perhaps it

was possible for Kelly and Bill to live together. He would bring this up as a possible option at the meeting. Bill's face lit up when Alan mentioned the idea of living with Kelly. Kelly was his best friend and although he was angry at him for leaving him behind, he missed him terribly. He would love to live with him. He hoped that Kelly was not mad at him for not coming to visit.

Within the next few days, Alan was able to reach Kelly. Kelly had been lonely since leaving the nursing home and missed Bill. He really liked the idea of the two of them living together. But Kelly's apartment was a one bedroom unit. They needed an apartment with two bedrooms. Alan immediately contacted the housing coordinator who discovered an available two bedroom apartment in Kelly's building.

Bill could not believe how everything was working. He was going to get out of the hateful old nursing home and spend evenings with Kelly playing games and maybe find a job during the day. He could not remember when he was so happy. During their next meeting, Alan shared with Bill that he would have a budget of \$525 to cover apartment set up costs and by furniture. The CCCI social worker talked with Bill and his parents to make sure that transition to the community would go smoothly, including making sure that Bill had the necessary doctor appointments and referrals in place.

Bill was scheduled to be discharged on August 25. He crossed each day off his calendar to mark what he called "Getting Out Day." When he arrived at the new apartment, it was so good to see Kelly again. He had not seen him since he left the nursing home.

Over the next few months, Bill adjusted to living on his own and being the boss of his staff. This was not easy, but he was learning and getting a lot of help from his case manager, his parents and Kelly. At the three month interval when Bill completed his consumer satisfaction survey he said that sometimes things were hard, but he was much happier than when he was in the nursing home. His parents noticed that his outbursts were fewer. He had enjoyed receiving some basic living skills training from a local training institute that his parents had located with the help of the transition coordinator. There was even a possibility of him getting a part-time job.

At the end of the first year in the community, Bill was doing very well. He enjoys his apartment, roommate, and part-time job sacking groceries at the grocery store down the street. During his annual Level of Care reevaluation and needs assessment, he was informed that he was no longer in the demonstration but that he was now formally enrolled in the ABI waiver. His services were not affected

Appendix P: Emergency Back-Up

Emergency Back-up

Connecticut's comprehensive back-up system will operate as follows:

There will be one central toll free line for all MFP participants to provide 24/7 assistance and back-up support for services that were not delivered which place the participant at risk. This back-up function will be contracted to Connecticut Community Care Incorporated (CCCI). CCCI will maintain a data-base of all MFP participants. The data-base will be secured on a lap top computer. A single page 'face-sheet' will be created for every participant listing the most essential information. Additionally, CCCI will maintain a copy of the participant's plan. This information will be transmitted directly from the transition coordinators to CCCI upon discharge from the institution and updated as needed.

During normal business hours, all calls will be answered on a CCCI 'must answer' line. After hours, the calls will be answered by a 24 /7 receptionist. Regardless of who answers the first call, the determination regarding the urgency of the matter will be made immediately. (Can this wait?) If the situation warrants immediate attention, the caller's information will be transferred immediately to the on-call staff.

The on-call staff will have access to the data base at all times. They will determine the appropriate response. There are three possible scenarios: 1) this is not an emergency; 2) this is a medical emergency – 911; 3) this is a high risk back-up emergency. (There are immediate concerns regarding health and safety of the participant if back up services are not located.) For callers who have emergency needs where expertise lies in other 'on-call' organizations, the triage system will immediately connect the participant to the appropriate assistance. The MFP back-up triage service will assure parties are in communication before disconnecting. For example, if the triage service receives a call from a DMHAS client in crisis, the caller will immediately be connecting with the DMHAS crisis hot line.

Documentation on all calls will be logged and transmitted monthly to the DSS MFP Director. Call logs will include the participant's name, nature of the call, and response of the nurse. Documentation on all calls requiring emergency back-up will be transmitted within 24 hours to the MFP Director who will forward information immediately to the agencies sharing responsibility for the participant. Language line will be used to assure the language capacity necessary to meet the needs of a diverse group or participants. For participants who access the 24/7 system two times in one month, care plans will be reassessed within three days of the second call.

Registries of emergency back-up staff will be developed through the fiscal intermediaries. Connecticut will offer an additional stipend to all personal care attendants who provide emergency services in order to create an incentive for on-call duty. This will be an additional new service option under demonstration services for the MFP.

Connecticut Community
Care, Inc.

43 Enterprise Drive
Bristol, CT
Tele: 860-589-6226

24/7 Emergency Back-up/Triage Service

Department of Social Services
Money Follows the Person Demonstration

24/7 Emergency Back-up/Triage Service

DSS/MFP Demonstration Project

Project Purpose:

The 24-hour back-up system is designed as one intervention that is part of Connecticut's MFP quality improvement initiative focusing on the improvement in workforce reliability. Data collection, documentation and analysis regarding real or perceived workforce reliability issues will occur.

Emergency Defined:

The toll free line will receive all emergency calls, critical incident calls, all reports of abuse and neglect, etc.

Emergency calls:

- This is a medical emergency – 911
- There is risk to the participant if:
 - Back up staff is not sent
 - Back up transportation is not sent
 - Back up equipment is not sent or malfunctions

Critical Incident calls:

- DSS defined expectations

Reports of abuse and neglect:

- DSS defined expectations

Emergency Toll-Free Line and Communications:

CCCI will establish a toll free emergency back-up/triage service through telephonic and electronic communication systems. As part of the demonstration project, transition coordinators and care plan personnel should maximize communication assistive technology to support the highest level of independence. CCCI will employ state-of-the-art technology and assistive technology to facilitate 1:1 communications with the MFP participant. Two telephone lines will be secured: voice and a dedicated TTY. Both telephone lines have forwarding capacity to an after-hours on call staff person.

The telephonic and electronic communications system has the capacity to perform:

- Live transferring to another emergency response line (mobile crisis, etc.)
- Caller telephone number identification
- Caller identification with pop up pre-loaded dataset of consumer
- Call volume and response time logs
- TTY automatic answer
- TTY alert to the triage personnel (land-line or cell-line)
- Instant messaging, email and text capability

Hours of Service

CCCI's work day hours are 8:00-4:30. The 24/7 Emergency back-up/triage voice line will be forwarded to an answering service. The answering service will provide light triage (is this an emergency, can it wait until 8:00 a.m. An on-call professional will directly receive all TTY, instant messaging, email and text communication 24/7.

Recommended Intake Forms:

- Prior to discharge, emergency (911) personnel will be notified of consumer special emergency needs through current state-wide notification system. It is recommended that all consumers/care planners/transition coordinators complete and submit this form.
- Emergency back-up dataset completed by consumer/care planning professional (or transition coordinator) and submitted to CCCI.
- Contact information provided to consumer for 24/7 emergency back-up/triage service
- What is an emergency - tip sheet
- Conservatorship Notification Agreement (if applicable)

Recommended Emergency Back-up Dataset:

CCCI in collaboration with stakeholders will provide the MFP Director with a standardized emergency data sheet for use with the 24/7 emergency back-up/triage service. Required data for care planning staff/ transition coordinators include:

Name		
Address		
Date of Birth		
Primary communication/contact information	Landline Cell phone Email	

Special housing access considerations	Locked front entrance Parking Other	
Conservator/Guardian contact information		Conservator/Guardian reporting agreement on file? Yes/No
Other legal representative		
Primary and secondary emergency contact		
Medicaid/Other Insurance		
Care Plan agency:		
Plan of care		
Consumer identified back-ups/for which service		
Consumer/Professional identified Medical/Health management/treatment issues that may require emergency back up:	Diagnosis: Treatment/possible intervention needs: Consumer/professional identified mandatory back-up need Consumer/professional identified intervention time frame: Is their a wellness agreement in place (WRAP)	
Consumer/Professional identified medical equipment reliance that may require emergency back up:	Consumer/professional identified mandatory back-up need Consumer/professional identified intervention time frame: Supplier: Equipment:	
Consumer/Professional identified transportation reliance that may require emergency back up.	Consumer/professional identified mandatory back-up need Specialized transportation needs:	

Recommended Dataset updating:

It is recommended that dataset updating be faxed or emailed to CCCI as changes occur. Web portal live updates under current review. Individualized emergency back up plan will be developed prior to transition to the community for each consumer.

DSS Reporting Requirements:

DSS defined – further discussion

Volume:

Year One **Year Two** **Year Three** **Year Four**

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