Nursing Home Admission/Discharge

**Nursing Home Admission:**

* Contact Nursing Facility and confirm participant’s admission date within 1 business day of notification
  + Review participant’s need for admission with NF staff
    - Short Term/Rehabilitation stay vs long-term placement
* Contact Service Providers immediately, by phone
  + Notify of service cancellation
* Update Status Report and submit to Case Tech for entry
  + If a participant is closing due to long-term placement, Waiver closure date must be the day before admission. Participant must have status of Waiver-Ineligible for the day of admission/day of program closure.
  + If a participant is closing due to short-term/rehabilitation stay, Waiver closure date must be the day before admission. Program status must be Waiver-Ineligible for the length of time the participant is in the nursing facility.
* Complete Waiver Disenrollment form and email to Medicaid Specialist
  + Disenrollment date MUST be the day BEFORE admission to the Nursing Facility (must match COMPASS status report)
* Update work orders and submit to Case Tech for entry
  + CANCEL services – must match Waiver disenrollment date
  + If participant will be returning to the home (short-term stay) and would like to keep existing PERS unit, notify Waiver Director and request use of 221 funds
* Complete Adverse Benefit Determination
  + Identify every Waiver Service being stopped, the provider, and the frequency as well as noting MI Choice Disenrollment.
  + Do not use abbreviations or acronyms
  + Mail copy to participant; place copy in UPCAP file

**Participant Discharge Home (only existing participants):**

* Coordinate with Nursing Home to determine discharge date and needs
  + Request discharge paperwork and facility notes
  + Meet with participant prior to discharge, if possible, to discuss services needed
* Contact Service Providers, by phone, to inquire re: available services
* NFLOCD and FOC must be completed and submitted to Case Tech to be entered on the day of discharge
  + Existing NFLOCD can be adopted by UPCAP if Supports Coordinator is not able to complete a new NFLOCD before discharge
    - Must notify Case Tech of request to adopt NFLOCD in CHAMPS
    - CHAMPS FOC will be populated and must be signed by the participant before services can start
* Participant must be contacted within 24 hours of discharge, or notification of discharge
* Full Return Reassessment and new NFLOCD & FOC must be completed within 7 days of discharge home
  + Reassessment must be completed by both SW and RN disciplines
  + Note medication reconciliation and review
  + Services can resume prior to the reassessment being completed to ensure safe transition home as long as NFLOCD and FOC have been completed and entered into CHAMPS
* Update Status Report and submit to Case Tech for entry
  + Waiver-Pending program status starting day of discharge
* Complete Waiver Enrollment form and email to Medicaid Specialist.
  + Waiver enrollment date is day of discharge (must match COMPASS status report)
* Complete START Work Orders and submit to Case Tech for entry
* Updated PCSP and Back up plan must be completed and mailed to participant and all other specified supports as outlined in the plan of care. Copy placed in participant file.