Shawnee County
Community Developmental Disabilities Organization
"Your resource for connecting our community"

Subject: Targeted Case Management Service Requirements **Effective Date: 12-15-97**	**Reviewed: 08-24-09, 08-26-10, 08-22-11,08-27-12, 07-29-14, 07.25.16**	**Policy No: 06-009**
Revised: 11-05-01, 09-16-02, 04-17-03, 10-20-03, 04-01-04, 05-15-06, 08-30-07, 08-24-09,08-22-11, 07.25.16	**Forms:** 06-009-001 Service Provider Transition Checklist	

POLICY: ***As requested by the person or persons guardian, the affiliated Targeted Case Manager (TCM) will assist the individual and their support network to identify, select, obtain and coordinate both paid and unpaid or natural supports to enhance the person's independence, integration, and productivity consistent with the person's capabilities and preferences as outlined in their Person Centered Support Plan (PCSP).***

GUIDELINES:

1. Each affiliated Targeted Case Management Provider and Targeted Case Manager will accept full responsibility to provide all the components of TCM services as outlined by the State of Kansas and written in the Kansas Medical Assistance Program (KMAP) HCBS I/DD Targeted Case Management provider manual. This shall include, but is not limited to:
    a. Assessment: TCMs will assist the individual and their support network to develop and implement an ongoing process for determining the individual's preferred lifestyle, current strengths and weaknesses, as well as any resources which may be available to that person.
    b. Support Planning: TCMs will assist the individual and their support network to develop a person-centered support plan which is responsive to the person's preferred lifestyle as well as updating the plan as needed; build upon assessment information to assist the person in meeting his or her needs and achieving the person's preferred lifestyle; provide assistance to the person to become knowledgeable about the types and availability of community services; provide information regarding the rights of persons served pursuant to the developmental disabilities reform act; obtain the community services of the person's choice.
    c. Support Coordination: TCMs will arrange for and secure the supports outlined in the person-centered support plan; develop and access natural supports and generic community support systems, gain access to needed services and entitlements, seek modification of service systems when necessary.
    d. Monitor & Follow Up: TCMs will monitor ongoing activities that are necessary to ensure that the person-centered support plan and related supports and services are effectively implemented and adequately address the person's needs.
    e. Transition Assistance & Transfers: TCMs will assist the person and the person's support network to plan and arrange for services to follow the person when the person moves from:
        i. School to the adult world
        ii. An institution to the community setting
        iii. One provider to another
        iv. One service area to another service area
        v. One service to another service setting

2. TCMs are responsible for facilitating a transition meeting between the current service provider support network and new service provider support network prior to the transition to new services occurring. Any and all relevant information will be shared in a timely and collaborative manner. Transition meeting minutes are to be completed on form 06-009-001 which is located in the BCI web-based system. The Funding Coordinator, Quality Management Coordinator/Transition Coordinator will receive an email notification when the transition meeting checklists are submitted.

3. Service provider transitions will be monitored by the CDDO.