| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-02558 (09/2020) | | | **STATE OF WISCONSIN** | | | | | | | | | | | |
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| **FAMILY CARE MEMBER COUNTY NOTIFICATION** | | | | | | | | | | | | | | |
| **INSTRUCTIONS** | | | | | | | | | | | | | | |
| The purpose of this form is to enhance coordinated planning efforts and provide information sharing between counties and managed care organizations (MCOs) when there is an assessed need to coordinate services with a county, or upon request from a county.  **Instructions for MCOs**   * The MCO will complete and send this form prior to a move when there is an identified need to coordinate services, such as court ordered commitments or any risk factors that indicate a need to inform county crisis programs, emergency mental health services, or Adult Protective Services; or * A “Yes” response to any of the items in the “Emergency services and county coordination” section of this form; or * Upon request from a county to provide the information for a specific individual. * Provide a copy of the completed form to the county or counties the individual may have contact with to coordinate services, and the residential provider if the person will receive services in a residential setting. * Save the file as: Last name-First name-Date notification form is completed (e.g., Smith-John-06-14-2019). * **Encrypt the file prior to sending via email. This form contains protected health information (PHI).** * If the MCO staff person completing the form is unsure who to send the form to at the county:   + Ask supervisory staff.   + If MCO supervisors or managers are not certain who to contact at a county, start with the county adults-at-risk contact and ask the county for a primary contact to receive this information. Find contact information at [www.dhs.wisconsin.gov/aps/aar-agencies.htm](http://www.dhs.wisconsin.gov/aps/aar-agencies.htm).   + Ask the county agency representative for the established contact to receive notifications and updates regarding Family Care members.   **Updates To Existing Forms**   * MCOs must update this form and provide a copy to the county or counties involved when:   + The member changes addresses within the county where they live.   + The member moves to another county.   + Important details in the member’s situation change.   + The member disenrolls from the MCO.   + A county requests the form be updated. * MCOs are responsible to maintain a tracking sheet to document when updates about a member are provided to the counties.   If a member moves voluntarily to a county in which the MCO does not operate, the MCO will use the Change Routing form.  In instances in which the individual or their guardian does not provide a written release of information, the MCO will convey only the essential information about the individual to ensure appropriate service coordination (per Wis. Stat. § 46.22).  **Instruction for Counties**:   * Maintain the notification files in a confidential location so that only the appropriate county staff may access the information. Electronic health records or a shared drive with a folder for each individual saved by “Last name, First name” is a recommended file saving protocol. Develop an internal policy or protocol for providing information about an individual needed to coordinate services with entities, such as mobile crisis staff, corporate counsel, APS staff, or the ADRC. | | | | | | | | | | | | | | |
| **Basic Information** | | | | | | | | | | | | | | |
| Reason for Submission:  Affirmative Emergency Services and County Coordination Item  Change of Address  Disenrollment  Other – Provide reason: | | | | | | | | | | | | | | |
| Date form sent to county:       Name – Form submitted by: | | | | | | | | | | | | | | |
| **Member Information** | | | | | | | | | | | | | | |
| Name – **Member** | | | | Date of Birth (mm/dd/yyyy) | | | | | | | Sex  Male  Female | | | |
| Address – Street | | | | City | | | | | | | State | Zip Code | | |
| Phone Number | County | | | Planned Move Date (mm/dd/yyyy) | | | | | | | Family Care Target Group  I/DD  FE  PD | | | |
| **MCO Information** | | | | | | | | | | | | | | |
| Name – **MCO** | | | | | | | | | | | | | | |
| Name – **Care Manager** | | | | Phone Number | | | | | Email Address | | | | | |
| Name – **MCO Staff Supervisor** | | | | Phone Number | | | | | Email Address | | | | | |
| **Residential Provider Information** | | | | | | | | | | | | | | |
| Provider Type:  1-2 Bed AFH  3-4 Bed AFH  CBRF  RCAC  Other  N/A | | | | | | | | | | | | | | |
| Name – **Residential Provider Agency** *(if applicable)* | | | | | | | | | | | | | | |
| Phone – General House Phone Number | | | | Email Address | | | | | | | | | | |
| Name – **Emergency On-Call Contact** | | | | Phone – On-Call Number | | | | | | | | | | |
| **County of Responsibility** | | | | | | | | | | | | | | |
| County of Responsibility on Record with MCO | | | | Name(s) of Crisis Program or Legal Representative Contacts | | | | | | | | | | |
| Address – County of Responsibility | | | | City | | | | | | | State | | Zip Code | |
| Phone Number | | | | Fax Number | | | | Email Address | | | | | | |
| **Member Legal Status and Background Information** | | | | | | | | | | | | | | |
| Does the member have a legal guardian?  Yes  No | | | | Name – **Guardian/Legal Representative** *(if applicable)* | | | | | | | | | | |
| Phone Number – Guardian/Legal Representative | | | | Email Address | | | | | | | | | | |
| Name – Family/Spouse/Next-of-Kin | | Relationship to Member | | | | | Phone Number | | | Email Address | | | | |
| Name – Family/Spouse/Next-of-Kin | | Relationship to Member | | | | | Phone Number | | | Email Address | | | | |
| Member’s Preferred Support Contact | | Relationship to Member | | | | | Phone Number | | | Email Address | | | | |
| **First Responder Quick Reference Information** | | | | | | | | | | | | | | |
| Things to know about member: | | | | | | | | | | | | | | |
| What is helpful when approaching or talking with member? | | | | | What is **not** helpful when approaching or talking with member? | | | | | | | | | |
| Who are support people who can help when member is in a crisis? | | | | | | | | | | | | | | |
| What behaviors should you be aware of in regards to safety of the member or others? | | | | | | | | | | | | | | |
| What helps the member de-escalate and calm? | | | | | | | | | | | | | | |
| **Emergency Services and County Coordination**  If the answer to any of the questions in this section is yes, then provide a copy of this completed form to the county where the person lives. | | | | | | | | | | | | | | |
| Does the MCO intend to make a referral for a Wis. Admin. Code ch. DHS 34 Crisis Plan with the county?  Yes  No  (Note: This notification form does not constitute a request for the county to develop a Crisis Plan.) | | | | | | | | | | | | | | |
| Was a Wis. Admin. Code ch. DHS 34 Crisis Plan developed for this individual in the past?  Yes  No  **If yes** – Indicate when and in which counties, if known: | | | | | | | | | | | | | | |
| Does the individual have a history of unplanned contacts with first responders or law enforcement?  Yes  No | | | | | | | | | | | | | | |
| Does the individual have an irreversible dementia diagnosis?  Yes  No | | | | | | | | | | | | | | |
| Does the person have a court ordered commitment (Wis. Stat.ch. 51), or a protective placement\* (Wis. Stat.ch. 55) or protective services order in place?  Yes  No  (\*Note: Members who are protectively placed require a 10-day notice to the county that issued the order prior to a move.)  **If yes** – Indicate the county court system involved, the type of order, the associated dates, and when the county court system that issued the order was notified of the change in placement. In addition, list any other legal status considerations, such as Wis. Stat. ch. 51 settlement agreements, conditional release or probation orders, or other criminal justice involvement: | | | | | | | | | | | | | | |
| Was the person in an Institute for Mental Disease (IMD) within the last three years?  Yes  No  Unknown | | | | | | | | | | | | | | |
| **Plan Information** | | | | | | | | | | | | | | |
| What prompted the need to move? | | | | | | If Other – Explain: | | | | | | | |
| Is the move intended to meet a short term-need for care or services? | | | | | | | | | | | Yes  No | | | |
| Is there a current Behavior Support Plan or other Behavioral Health or Wellness Plan in place? | | | | | | | | | | | Yes  No | | | |
| Were there unsuccessful residential placements in the past year?  **If yes**, please list the causes: | | | | | | | | | | | Yes  No | | | |
| Is there a plan for respite or diversion for short-term stabilization?  **If yes** – List the contact information for any alternate providers that may be utilized: | | | | | | | | | | | Yes  No | | | |
| Is there a need for 24-hour staffing/supervision due to behavioral health needs or other risks? | | | | | | | | | | | Yes  No  Unknown | | | |
| Is a Behavioral Restrictive Measures Application in progress or currently approved for the member? | | | | | | | | | | | Yes  No  Unknown | | | |
| Briefly explain the plan to support the person’s needs for housing, services, and the planned staff ratio: | | | | | | | | | | | | | | |