| **Subject: Targeted Case Management Service Requirements**<br>**Effective Date: 12-15-97** | **Reviewed: 08-24-09, 08-26-10, 08-22-11,08-27-12, 07-29-14, 07-25-16, 09-27-17, 10-15-18** | **Policy No: 06-009** |
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| **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, 09-27.17, 11-15-18 | **Forms:** 06-009-001 Service Provider Transition Checklist | |

**POLICY:** ***As requested by the person or person's 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 TCM Provider and TCM 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 TCM 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 PCSP 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 PCSP; 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 and Follow Up: TCMs will monitor ongoing activities that are necessary to ensure that the PCSP and related supports and services are effectively implemented and adequately address the person's needs.
   e. Transition Assistance and 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. All relevant information will

be shared in a timely and collaborative manner. Transition meeting minutes are to be completed on Transition Checklist form (06-009-001) which is in the BCI web-based system. The Funding Coordinator and Quality Management Coordinator will receive an email notification when the transition meeting checklists are submitted.

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