Section D: Eligibility and Admissions

POLICY STATEMENT: Eligibility and Admissions

Adopted by the Board of Directors 02/23/2017

It is the policy of Open Options to serve individuals with disabilities, and their families, provided that:

a) The individual's needs can be met directly by the program or through cooperation with community resources, and no alternative, more appropriate service or agency is available;
b) The individual meets entrance criteria for the specific program which he/she has selected to meet his/her needs;
c) Information required to assess the ability of the program to meet the individual's needs is received prior to initiation of services;
d) Required admission, informed consent, and enrollment forms are signed.

No person shall be excluded from services, or subjected to any form of discrimination, including disparate treatment, based on age, race, ethnicity, religion, national origin, sex, disability or veteran status.

Admission procedures shall include specific written criteria for acceptance to each program of the organization which allow potential persons served and funding sources to judge the appropriateness of the services offered by the organization. Admission procedures shall establish guidelines for actions to be taken and assignments of responsible parties. Persons accepted for services, their family members and other people they rely upon are informed of their responsibilities regarding the services they will receive prior to the onset of services.

ELIGIBILITY AND INTAKE

PROCEDURE - All Programs

A person served may be referred to the organization by another agency, family member, self, physician, guardian, or other advocate, or through the referral database facilitated through the Department of Mental Health, via a phone call, e-mail, referral packet, letter, or walk-in to the organization.

Upon referral to the organization, the relevant Director will complete an initial screening. The person-centered plan and other relevant documentation is reviewed and discussed with the referring person(s). If this initial screening determines the referral is a potential fit, the Director of the program will meet with the prospective person served and/or referral source. The Director shall determine: a) whether the individual is eligible for services based on criteria for the specific program, b) whether the program or service has current capacity to meet the individual's needs, and c) whether funding is available for the desired services. The Director shall also provide information about the organization and specific program(s) to the prospective person served and/or family. The individual and/or the referral source shall be informed of the individual's eligibility status and the reason for the determination. This may be communicated in verbal or written form, and shall be noted on the Intake/Referral form.

If the individual is determined to be eligible for services, there is current capacity to meet the person served's needs, and appropriate funding is available, admission procedures for the specific program services will be followed under the direction of the Director. (See Eligibility and Admission Procedures for specific program services and locations.)

In instances in which an individual is determined to be eligible, but services cannot be provided due to program capacity

or funding issues; and in instances in which an individual is found to be ineligible for a specific program, but may be eligible for an alternative program within the organization, the referral will be pursued in that program.

If the individual is determined to be ineligible for all programs and services offered by the organization, the individual and/or referral source shall be informed, including reasons for ineligibility. Whenever possible, the individual will be given information regarding alternative community resources.

Referral information received shall be regarded as confidential. Referral information shall be maintained or summarized for periodic review to analyze trends and to identify service needs.

ELIGIBILITY AND ADMISSION

PROCEDURE - Community Living Programs

The Director of Quality Enhancement and Director of Community Living are responsible for eligibility and admission decisions, and may do so in consultation with other program personnel. Prior to making a final eligibility and admission decision, the Director of Community Living will notify the President/CEO or designee of the preliminary decision for approval. Community Living services of this organization are available to persons whose developmental disability is preventing independence in one or more major life functions. Specific eligibility and admission criteria are outlined for each program.

Eligibility and Admission Criteria and Evaluation – All Community Living programs

The Director of Community Living and Director of Quality Enhancement will evaluate each referral for Community Living services based upon the following factors. This evaluation is intended to increase the probability for a successful outcome of services by matching needs and desires to service settings and support levels.
Persons considered for admission must be:

a) Sixteen years of age or older - Individualized Supported Living Arrangements may accommodate persons at a younger age, provided that compatible, age-appropriate roommates are served in the same household. Community Integration services may be provided to younger persons living in the family home or a group home;
b) Diagnosed by the Missouri Department of Mental Health (or other qualified psychological evaluation) as "developmentally disabled" as defined by Missouri State Law;
c) Living within the Greater Kansas City area (or desire to live in the service area);
d) Assessed or documented ability to live safely with a level of support which is provided or can be funded, including but not limited to: response to emergency warning systems, responsibility with medications and household chemicals, use of public or specialized transportation systems, safe use of available appliances, problematic behavior that poses risks to well-being of others, and general home and community safety;
e) Free of health conditions which require continuous on-site surveillance by professional medical personnel;

The organization reserves the right to accept or reject any person for services based on these factors:

a) The preferences and choice of the referral or the persons currently served in the program – the person served has communicated he/she does not wish to be admitted to the program, or the persons currently being served in the

program have communicated they do not wish to have the referred person served live with them.

b) Support team communication - The organization believes there is inadequate, uncooperative, or inappropriate communication between support team member(s) that either disrupts or inhibits the organization from effectively meeting the needs of the persons served.
c) Inappropriate level of care or restrictive environment – The program or service environment provides a higher level of care or is more restrictive than the person served requires, or the program or service environment does not provide the necessary level of care or restrictive environment that the person served requires.
d) Inadequate funding – the assessed support needs of the person served cannot be met with the funding authorized.
e) High risk behavior – record of high risk behavior including but not limited to physical or sexually assaultive behavior, intentional destruction of property, serious theft or other significant challenges to the physical or emotional well-being of others.
f) Medical Risk –the program is unable to adequately meet the medical, physical, or mental health care needs of the person served, or there is inadequate documentation to adequately meet the medical, physical, or mental health care needs of the person served.
g) Lack of accessibility – the program or service location does not provide for adequate architectural or environmental accessibility for the person served.
h) Need for placement – When service capacity is limited and more than one individual is being considered for services, the degree of each person's need for program services shall be taken into consideration.

All prospective program participants seeking services will visit the program location prior to acceptance for admission. Persons served and their families/advocates will be provided with information about the organization and services offered. Because we rely upon persons seeking services, their advocates, and the referral source to help evaluate the appropriateness of each service for the needs and goals of the person to be served, we provide the following statements of program goals.

- **Group Living Program Goal:** The goal of the group living program is to provide supports to develop daily living skills, facilitate community inclusion, and achieve person-centered outcomes. These services are provided in homes owned or leased by Open Options. These program locations are operated 24-hours a day 365 days a year.

- **Individualized Supported Living Program Goal:** The goal of the program is to assist individuals in maintaining a home and roommate relationships of their choice, provide an individualized level of support, teaching, and direct assistance under a flexible plan of service, and support individuals to achieve person-centered outcomes. These services are provided in person served's homes which are leased, rented or owned by the person served, with staffing support up to 24-hours per day. The specific days and hours of program operation are person-specific and established in the approved ISL Staffing Pattern.

- **Community Integration Services Program Goal:** The goal of the program is to achieve person-centered outcomes and enhance integration and membership in the individual's chosen community. This is accomplished through participation in a range of activities in the community and through the provision of ongoing supports as agreed upon by the support team and outlined in the person-centered plan to assist the individual in maintaining status in the community. Services may supplement and/or facilitate natural supports for the individual. For this program, specific days and hours of program operation are not dictated by an approved Staffing Pattern, but are person-specific and established by the person served's support team. The total hours of service provided (indicated in units) is approved annually and indicated in the person served's Individual Plan of Care.

The organization may request that additional written risk assessments be provided prior to initiation of services. These processes are used to assist in determining if the individual's support needs can be met by the program. Provision of this information does not guarantee that all of the identified "risks" can be effectively addressed or eliminated if the individual is admitted for services.

Prior to admission or transfer, the Director will arrange a meeting with each candidate to the program and relevant members of the existing support system (family/guardian, current support employee(s), Support Coordinator) to discuss the level of support needed by the individual receiving services. Information about the organization and services offered will be shared with the prospective person served and support team. If a Person-Centered Plan is not already in place, or if major revisions to an existing plan need to be made, relevant support team members will be included in the meeting and the Support Coordinator is responsible for completing any updates or addendums. The support team and the organization would then determine a start date for services.

When a person is being considered for admission to Community Living Services, the following information should be provided:

a. Services/Treatment Info:
   1. Individual Support Plan and all applicable Addendums
   2. How to Best Support (details of safety, medical, behavioral, psychiatric, level of supervision needs, etc.)
   3. Guardianship/family contact information
   4. Copy or original Birth certificate
   5. Personal ID Cards (photo ID, social security, food stamp, Medicaid, Medicare, and other insurance)
b. Medical Info:
   1. Physical exam from within the last year.
   2. Dental exam from within the last year.
   3. Vision exam from within the last year.
   4. Supply of all medications and pharmacy information (address, phone number, contact names)
   5. MAR (for current month and previous two months)
   6. Physician Orders (for current month and previous two months)
   7. Side effects sheets for all medications
   8. Allergy information
   9. Immunization record
   10. Hepatitis B screening (and/or immunization or signed declination form)
   11. Lab reports (including TB test results from within the last year)
   12. Community RN summary for past 90 days
   13. Evaluations/consultation forms from medical specialists
   14. Past medical records (from Regional Office and/or provider)
   15. List of all physician names and contact information
   16. List of upcoming appointments and information on any necessary medical followup
   17. Copy of any DNR, alternative CPR methods, and Advance Directive (if applicable)

   18. Copy of specialized protocol/procedures for monitoring medical/safety conditions (for example but not limited to blood sugar, seizures, dietary concerns, choking precautions, vent care, trach care, preventing impactions, maintenance schedule for adaptive equipment)
   *If any medical information or exams have not been completed, the Open Options Health Services Coordinator

should assist with getting the exam scheduled and completed within the first 90 days of service.

c. Financial/Personal Property Info:
   1. Personal spending funds on account
   2. Banking information (i.e. account numbers/cards, supply of checks)
   3. Possessions – inventory items (clothing, furniture, adaptive equipment, etc)
   4. Ledgers and receipts for personal expenditures
   5. Eligibility for assistance programs

Referral information shall be submitted to the Director Community Living and/or other appropriate employees for review. If additional information is required, a written or verbal request to the referral source. If requested information is not available, or request is not honored, dates and efforts to procure the information shall be documented. Failure to provide necessary information may result in a determination of ineligibility for program admission or postponement of admission until the information is received.

At the intake meeting, or prior to if practical, each person served will be provided with a "New Person Served Information Packet" which provides at least the following information:

a) A description of the organization and specific program, its services, and costs.
b) Information as to how to seek discharge or termination of services.
c) A statement of rights assured by law and organization policy, and program limitations on those rights.
d) Grievance procedures.
e) "Expectations and Responsibilities" (if any) as applicable to service location or program.
f) A description of the Person-Centered planning process (including active person served participation and the name of the person(s) responsible for coordinating services).
g) Information regarding service capacity, employee qualifications, conflict of interest, and approaches to risk vs. choice, including specific organization policies as applicable.
h) Notice of Privacy Practices

Information shall be provided to the person served in an accessible or understandable format. If a person served cannot read and understand the information, it shall be explained to him/her and/or his/her parent or guardian.

<u>Additional Procedures – Supported Living and Community Integration</u>
Housing selection may be done with or without employee assistance. Candidates will be informed of agency minimal standards for housing, and the organization reserves the right to refuse services to persons served whose housing does not meet these standards.

Based on input from the team (including the person served) regarding level of support, the Director of Community Living or his/her designee will develop an Individualized Supported Living Budget, and/or request for community integration funding units, to be submitted to the appropriate Support Coordinator for submission to the applicable funding source(s) for approval. Whenever possible, a signed, approved budget must be received by the organization prior to the initiation of services.

Cost of Services & Payment
The cost of services varies per program service and is set through contracts with funding sources. The exact cost and the method of payment will be communicated to the person served /guardian upon request prior to or upon admission. If an

individual is paying for services from private pay, the cost of payment will be equal to the established rate with Department of Mental Health based on the program location and service.

Open Options is not able to provide community living services to persons unable to pay due to lack of public fee sponsorship or private financial resources. The Director of Community Living will provide a fee schedule to such parties and refer them to the appeals process of the Department of Mental Health or applicable funding agency.

Fee splitting with other agencies, public or private, or with individuals as consideration of referrals of persons to be served is prohibited.

ELIGIBILITY AND ADMISSION

PROCEDURE – Information & Referral Program

Specific Eligibility / Admission Criteria - Information & Referral Program

The primary goal of the program is to strengthen individuals with disabilities, and their families, by providing access to a variety of supports which will increase their ability to live well within their local community. This may be accomplished through individual and family counseling and adjustment planning, referral and links to supports within the organization or available in the community, advocacy, and provision of opportunities for support and recreation with others. The Director of Community Living will share information regarding types of programs or services available through the organization and other service providers, and other pertinent information applicable to the person served's needs.

Persons considered eligible for services must:
a) Have a diagnosis of intellectual or developmental disability, or other similar condition or disability, OR be a family member, professional, or person acting on behalf of a person with a disability;

All persons requesting information and referral services, regardless of disability or diagnosis, may receive information from Open Options. Other eligibility guidelines may apply for specific programs.

PROCEDURE – Kansas City Power & Speed Sports Program

Specific Eligibility / Admission Criteria – Kansas City Power & Speed Sports Program

The goal of the program is to provide a year-round training program designed for athletes with disabilities to develop sports skills, improve physical and mental fitness, and enjoy an atmosphere of individual and team goal setting. It is also recreational with fun experiences and the opportunity to travel to local, state, regional, national, and potentially international meets.

Persons considered eligible for services must:
a) Be eight years or older,
b) Experience a physical, intellectual and/or developmental disability

c) Reside in the Greater Kansas City area,
d) Be willing to adhere to the rules and guidelines of the national or international sports sanctioning organization applicable.

When an individual is determined to be eligible for the program, he/she (or a family member/other support, if applicable) will be provided with information about the program and upcoming sessions, and the Notice of Privacy Practices. Training may be offered at varied times throughout the year and at varied locations.

PROCEDURE - Targeted Case Management Program

Specific Eligibility / Admission Criteria – Targeted Case Management Program

The goal of case management services is to assist the person and his/her support network to identify, develop, select, obtain, coordinate, utilize and monitor paid services and natural supports to enhance the person's independence, interdependence, productivity, and quality of life consistent with the person's needs and preferences as outline in the person-centered plan. Case management services consist of assessment, support planning, support coordination, monitoring and follow-up, and transition / portability assistance.

An individual eligible for I/DD services through the Community Developmental Disability Organization (CDDO) may be referred to Open Options for Targeted Case Management Services through processes and forms defined by the CDDO. Upon referral, the team of Support Coordinators will consider the status and needs of the individual and the current capacity within Open Options's caseload. "BASIS" assessments, background information, and information on all current supports must be provided for the person served referred, and an interview may be requested. The Information, Referral, and Support Coordinator or designee will evaluate each referral for service, and determine if current needs can be met by current case management employees. Upon determining that the individual will be served, the referral form is signed by the Family Support Program Manager or the President/CEO and returned for processing to the CDDO. All individuals with an I/DD diagnosis are eligible for admission to the Open Options program, but must reside in either of the Kansas counties of Johnson or Wyandotte.

Those who do not reside in the Open Options area of service are rejected and reasoning is submitted to the CDDO either in writing or over the phone. See section on Determination of Ineligibility.

A case file is established for the person served. The necessary Release of Information forms are signed, and the individual Support Coordinator meets with the person served and family as soon as a time can be arranged. The development of the Individual Support Plan begins at the first meeting. It is the responsibility of the Support Coordinator to have the PCSP written within 30 days of meeting with the person served and updated annually, as outlined in Kansas Department of Aging and Disability Services Article 63.

Determination of Ineligibility or Unable to Serve
When a person is directly referred to us and found to be ineligible for services, or the organization does not have the capacity to provide services, the person and the referral sources is informed of a) reasons he/she was determined ineligible or unable to be served, and b) potential other sources of services to meet his / her needs.

POLICY STATEMENT: Exit, Discharge and Transfer

Adopted by the Board of Directors 02/27/2017

It is the policy of Open Options that any person served whose needs are not being met by program services or who cannot benefit from any service provided by the organization shall be discharged. Specific examples of circumstances which may prompt a discharge decision include, but are not limited to:

a) Medical conditions requiring continuous professional medical surveillance, or deterioration in health status necessitating and increase in support which cannot be funded or provided in an existing agency program.
b) Malicious, chronic, and/or intentional property destruction, or physical aggression toward others, which endangers the physical or emotional well-being of others.
c) Self-abusive behavior that is life-threatening to the individual.
d) Actions by the person served and/or person served's legal guardian or family member which serve to continuously undermine or disrupt benefits of service.
e) Non-payment of fees.
f) Non-compliance with physician orders (assuming issues of informed consent have been resolved.)

A person served and his /her legal guardian where appropriate, may determine that the organization's services are no longer of benefit. Under such circumstances, exit from the program is appropriate.

It is in keeping with the policy of Open Options to seek a transfer between programs when a person served's needs could be better met in another facility or program within the organization. A discharge and transfer follow-up procedure will be established to gather information which may help analyze program effectiveness.

EXIT - DISCHARGE AND TRANSFER

PROCEDURE – Community Living Programs

In accordance with the organization's policy, any person served whose needs are not being met in any organizational program, or who cannot benefit from any current service provided by the organization, shall be discharged or transferred. Discharge/Transfer procedures are as follows:

a) The representative of the placing agency shall be informed of the person served's and/or organization's intent to begin discharge planning.
b) Whenever possible, a meeting will be held including a representative of each internal or external program or facility, the person served, parents/guardian, and a member of management. The purpose of the meeting will be to finalize decisions and/or plans, address the person served's immediate needs for a smooth transition, and seek appropriate referrals for service if needed.
c) For a transfer, admission procedures applicable to the appropriate programs will be conducted by the Director/Manager of the new program. An entry on the Person Served Information Sheet will document the date of transfer.
d) For discharge, an exit summary will be written within three weeks describing the reason for exit, recommendations for further service delivery, referral actions taken, and other pertinent information. A summary/status of current goals and outcomes will be included. Whenever possible, person served satisfaction questionnaires will be completed at the time of discharge. The exit summary shall be filed in the person served

record and, if appropriate, a copy sent to the new residential placement or referring agency. A copy of the report shall be filed for program analysis and planning.

No individual shall be discharged from the program due to religious beliefs, national origin, disability, sex, or race.

Follow-Up Procedure

Follow-up contacts may be made with any person served discharged or transferred within any program or facility. The purpose of follow-up contacts is to gather information which may help analyze program effectiveness and to assist the person served with successful transition.

Whenever possible, an "Authorization for Release of Information" should be obtained at the time of discharge applicable to any outside agencies involved in the follow-up process. At least one follow-up report shall be completed by the Program Director for each individual discharged from the program. The level of follow-up reporting will be determined by the team at the time of discharge planning. "Crisis" contacts may be made in the interim and shall be so documented. All Follow-up Reports shall be documented in the discharged person served's record within ten working days of the contact. The Director of Community Living shall ensure that a copy of each report, and any post-discharge questionnaires, are properly filed for review during program effectiveness analysis (program evaluation) and/or organizational planning.

Follow-up reporting for persons served who transfer to another program within the organization will consist of adjustment notes entered into the Person Served Support and ISP Data entries. For persons served who transfer within, most follow-up will be done on an informal basis by the Program Directors who link employees together for resolution to adjustment issues.