



**Community Services Procedure
Consultative Services Referral and Authorization
CS PRO 204**

Revision Date	Sections Revised	Description of Revision
3/18/2024	All	Origination date
Director's Signature/Date: <i>John Cash</i> 3/18/24		Effective: 3/18/2024

	<p>Community Services Procedure Consultative Services Referral and Authorization CS PRO 204</p>
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1. Purpose

To create a procedure for the referral, assessment/reassessment, and authorization for service recipients to receive Nurse Consultation and/or Behavioral Consultation services under the 1915(c) Lifespan Waiver operated by the Division of Developmental Disabilities Services (DDDS). Authorized hours of support are determined annually by use of the standardized Assessment of Need for Clinical Behavioral Services (ANCBS) or Assessment of Need for Clinical Nursing Services (ANCNS) as appropriate.

2. Scope

This procedure applies to contracted DDDS Authorized Providers and DDDS Community Services Employees.

3. Definitions

Support Team	The people selected by the service recipient to assist in person-centered planning and achieving the service recipient’s chosen “good life.” This includes (at minimum) the service recipient, legal guardian if one is appointed by the court, parent(s) and/or circle of support; DDDS Authorized Providers; Support Coordinator, Community Navigator, Family Resource Coordinator, or OBRA Case Manager (collectively referred to as “case manager” below.) The service recipient has the final decision about who is a member of their support team and/or who attends their team meetings.
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4. Procedure

Action by:

Action:

Support Team

- Identifies** possible need for consultative services, or change in current service needs, or:

- Case Manager
2. **Robust pre-planning for the service recipient’s annual Person-Centered Plan review** has begun and the service recipient wishes to continue to receive consultative services in the upcoming service year.
 3. **Contacts** legal guardian, primary caregiver, or other support team member to obtain contact information and confirm their agreement to be a respondent to the ANCBS/ANCNS.
 4. **Completes*** the ***Request for Assessment of Need for Clinical Services*** form (Appendix A) completely, including, but not limited to:
 - a. Name and contact information of the service recipient;
 - b. Whether the service recipient is able to answer questions on their own behalf;
 - c. Anniversary date of the service recipient’s Person-Centered Plan (PCP);
 - d. The reason for the referral (from drop-down list);
 - e. The requested start date for consultative services (the same date as identified in “c” if this is a referral for an annual re-assessment);
 - f. ICD 10 code used to apply for the waiver;
 - g. The type of assessment/reassessment requested source (from the drop-down list);
 - h. Selected or current consultative provider, if selected;
 - i. Name and contact information for the legal guardian (if one has been appointed by the court) who has agreed in advance to provide information for this assessment/reassessment;
 - j. Name and contact information for a primary caregiver or other support team member who has agreed in advance to provide information for this assessment/reassessment;
 - k. The funding source for the service recipient (from the drop-down list) and any comments pertinent to the funding source (i.e. LTSS transitioning to Lifespan Waiver, from drop-down list);
 - l. Case manager name and contact information;
 - m. Confirmation that the case manager has spoken to the legal guardian or other support team member who has agreed to provide information for this assessment.

****Incomplete forms will be returned to the Case Manager for completion and resubmission.***

Case Manager

- 5. **Submits** the *Request for Assessment of Need for Clinical Services* to:
 - a. the DDDS Behavior Analyst Supervisor (Marycarol.Bead@delaware.gov New Castle County or Karen.Blakely@delaware.gov Kent and Sussex Counties) for the county the service recipient currently lives in for Behavioral Consultative services, or;
 - b. the DDDS Service Integrity and Enhancement (SIE) Nurse Supervisor (Sharon.Bertin@delaware.gov) statewide for Nurse Consultative services, or;
 - c. one copy of the referral to the DDDS Behavior Analyst Supervisor for the county the service recipient currently lives in and a separate copy the DDDS SIE Nurse Supervisor statewide if the service recipient wants both Behavioral Consultation and Nurse Consultation services.

BA Supervisor/Nurse Supervisor or designee

- 6. **Contacts** the service recipient, guardian, and/or support team member within five (5) business days to complete the *Assessment of Need for Clinical Behavioral/Nursing Services (ANCBS/ANCNS)*.
- 7. **Saves** completed ANCBS/ANCNS in the service recipient’s file in R:/Benefits/Clinical Billing/Current Statewide Authorizations folder.

BA Supervisor/Nurse Consultation Program Administrator

- 8. **Notifies** SC/CN via email of eligibility for consultative services and funding level/units associated with that Level of Need for initial assessments/reassessments; or
- 9. **Notifies** SC/CN and current Authorized Consultative Service provider via email if the service recipient was determined not eligible for the consultative service through the assessment/reassessment or if changes in Level of Need were identified through the re-assessment.

Case Manager (for initial assessments only)

- 10. **Assists** individual and guardian to explore available resources for Authorized Consultative Service providers and select a provider (if one has not already been selected previously).
- 11. **Contacts** the selected authorized provider to verify availability and start date.
- 12. **Notifies** BA Supervisor/Nurse Consultation Program Administrator of selected Authorized Consultative Service provider and start date.

BA
Supervisor/Nurse
Consultation
Program
Administrator

13. **Completes** the Request for RN/BA Consultative Services (typically called the program authorization) (Appendix B) to include funding source and funding level/units determined in the ANCBS/ANCNS and sends a copy of the program authorization, through secure encrypted email, to the selected or current consultative service provider, the SC/CN, and to the DDDS Office of Business Supports and Services (OBSS) resource mailbox (dhss_ddds_nurseauths@delaware.gov for Nurse Consultation services, and dhss_ddds_baauths@delaware.gov for Behavioral Consultation services).

14. **Saves** completed program authorization in the service recipient’s file in R:/Benefits/Clinical Billing/Current Statewide Authorizations folder.

Office of
Business
Supports and
Services (OBSS)

15. **Processes** Authorization for Medicaid funding or 100% State funds.

Authorized
Consultative
Service Provider

16. **Monitors** the effectiveness of the consultative supports.


17. **Monitors** usage of authorized units.

18. **Discusses** with the support team (via phone, email or face-to-face) the need for reassessment if significant and ongoing changes in the need for consultative services is identified (Go to step 3).

5. Appendix


Appendix A – Request for Assessment of Need for Clinical Services Form

Appendix B – Request for RN/BA Consultative Services (typically called the “program authorization”)

 DELAWARE HEALTH AND SOCIAL SERVICES Division of Developmental Disabilities Services		Request for Assessment of Need for Clinical Services		
General Information	NAME OF INDIVIDUAL TO BE ASSESSED:		PCP ANNIVERSARY DATE:	TODAY'S DATE:
	IS INDIVIDUAL ABLE TO ANSWER QUESTIONS ON THEIR OWN BEHALF? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
	ENTER COMMENTS BELOW:		REASON FOR REFERRAL:	DESIRED SERVICE START DATE:
			Initial Referral	
	DATE OF BIRTH:	MCI#:	COUNTY OF RESIDENCE:	
		Sussex		
ICD 10 CODE:				
INDIVIDUAL'S PHONE NUMBER:				
Assessment Requested	TYPE OF ASSESSMENT Choose an item. Behavioral Consultation		IF YOU ARE REQUESTING A BA AND AN RN ASSESSMENT, PLEASE COMPLETE/SUBMIT A SEPARATE FORM FOR EACH REQUEST.	
	HAS THIS PERSON BEEN ASSESSED BEFORE? Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/>		ENTER COMMENTS BELOW:	
Provider Information	CURRENT PROVIDER AND AGENCY (IF APPLICABLE):			
	NEW PROVIDER IF THIS REQUEST IS TO CHANGE PROVIDERS:			
Legal Guardian Information	DOES THE INDIVIDUAL HAVE A LEGAL GUARDIAN? Yes <input type="checkbox"/> No <input type="checkbox"/>		NAME OF LEGAL GUARDIAN:	
	RELATIONSHIP TO INDIVIDUAL:			
	EMAIL ADDRESS:		TELEPHONE NUMBER:	
Primary Caregiver/ Additional Contact Information	PLEASE PROVIDE NAME OF AN AGREED UPON ALTERNATIVE CONTACT PERSON TO ANSWER QUESTIONS ABOUT INDIVIDUAL'S BEHAVIOR/MENTAL HEALTH/MEDICAL ISSUES, IF APPROPRIATE:			
	CONTACT PERSON'S NAME:		RELATIONSHIP TO INDIVIDUAL:	
	EMAIL ADDRESS:		TELEPHONE NUMBER:	

Funding Information	HOW WILL THIS SERVICE BE FUNDED: Choose an item. <input type="text" value="Lifespan Waiver"/>	LIFESPAN WAIVER SUBMISSION DATE: <input type="text"/>
		LIFESPAN WAIVER APPROVAL DATE: <input type="text"/>
ENTER COMMENTS BELOW: <input style="width: 100%; height: 40px;" type="text"/>		

Case Manager/Community Navigator Information	CM/CN SUBMITTING THIS REQUEST: <input style="width: 100%;" type="text"/>	
	CM/CN EMAIL ADDRESS: <input type="text"/>	CM/CN TELEPHONE NUMBER: <input type="text"/>
	HAS CM/CN CONFIRMED INDIVIDUAL/GUARDIAN/FAMILY AGREEMENT TO SERVICE? Yes <input type="checkbox"/> No <input type="checkbox"/> IF NO, DO NOT SEND THIS REQUEST PRIOR TO OBTAINING CONSENT FROM THE INDIVIDUAL/GUARDIAN.	
	DATE CM/CN SPOKE TO INDIVIDUAL/GUARDIAN/FAMILY: <input type="text"/>	VIA PHONE OR EMAIL: <input type="text"/>



STATE OF DELAWARE
DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

Request for Nursing Consultative Services

Name of Individual:

MCI #

ICD 10

Date:

Funding Source:

Authorized By:

Assessment Level:

Authorization Details

T1001

Start Date

End Date

Months between start and end date. Partial months (M) counted as full.

Requested units per date range

Funding Level: T1001 U1 T1001 U2 T1001 U3

Annual Support Units: \$18.77 \$19.63 \$23.02

Per Authorization Unit

Number of Additional Units:

Number of Consultative Units: 0

COMMENTS:

DBSS will assume the PCP start date is one day after end date for 12 months using annual support units noted above.

Current Nursing Provider (if applicable)

Provider Name:

Region:

Requested Nursing Provider

Provider Name:

Region:

In compliance with CMS regulations and per DHSS/DDDS Contract Appendix A, Section E.3.F, provider agencies may only bill for services that are actually provided. Appendix B, Section D.2.1 further provides that "The DDOS may audit any funds a contractor of HCBS/Other Services receives including documentation supporting the receipt of such funds".

Last Updated 07/17/2022



**STATE OF DELAWARE
DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

Request for Behavioral Consultative Services

Name of Individual	MCI #	ICD 10
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Date:	Funding Source:	Inquirer	State Funded
Authorized By:	Assessment Level:		

Authorization Details

G0175	Start Date	End Date	Health	Prevalence rate per date range
				0
Annual Support Units:		G0175 U1	G0175 U2	G0175 U3
Number of Additional Units:		\$16.61	\$21.84	\$28.27
Number of FBA Units:		<i>For Reference Only</i>		
Number of Consultative Units:	0			

COMMENTS:

DBSS will assume the PCP start date is one day after end date for 12 months using annual support units noted above.

Current Behavioral Provider (if)	Requested Behavioral Provider
Provider Name:	Provider Name:
Region:	Region:

In compliance with CMS regulations and per DHS/DDS Contract Appendix A, Section E.3.F, provider agencies may only bill for services that are actually provided. Appendix A, Section D.2.4 further provides that "The DDS may audit any funds a contractor of NCS/Waiver Services receives including documentation supporting the receipt of such funds".

Last Updated 8/17/2022