1915(i) COMMUNITY TRANSITION PLAN OF CARE AND REQUEST FOR FUNDS

North Dakota Department of Health & Human Services
Medical Services Division
1915(i) Form 4 (Rev. 2-2024)

The 1915(i) Community Transition Service (CTS) funding is for non-recurring set-up expenses for individuals who are transitioning from a nursing facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Qualified Residential Treatment Program (QRTP), Psychiatric Residential Treatment Facility (PRTF), or hospital (excluding the State Hospital and other hospitals which are IMDs) to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Instructions for Completing the Form:

This form must be completed by the case manager responsible for oversight of the CTS funding and for coordinating the individual's discharge planning. The form is submitted to the Medical Services 1915(i) Administrator via email to nd1915i@nd.gov to request approval for the CTS. The requestor will be informed by Medical Services of the approval or denial of the request. If approved, the requestor will complete Veridian Fiscal Solution's requirements for community transition purchases.

The "begin date" in the "Service Approval Dates" section must be 90 days or less prior to the individual's discharge from the institution.

The "proposed end date" in the "Service Approval Dates" section will be 180 days past the "begin date".

The service approval will automatically void when any of the following occur:

- It is determined the individual will not be discharged to their own home.
- The individual has not been discharged by the end of the 90 day period.
- The individual has not been found eligible for the 1915(i) by the end of the 90 day period.
- The individual is not living in their own home by the end of the 90 day period.
- The maximum approved money has been spent.
- At midnight on the "end date" which is a maximum of 180 days since the begin date.

The service approval will remain effective for up to an additional 90 consecutive days past the date of 1915(i) eligibility if all of the following are present:

- The individual has not spent the maximum authorized funding; and,
- The originating case manager agrees to continue to provide oversight of the CTS funding during the 90 day post-discharge period; and,
- The individual has been discharged from the institution; and,
- The individual has been found eligible for the 1915(i); and,
- The individual is living in their private home; and,
- The individual continues to have a need for the funding.

Eligibility Requirements

To be eligible for the community transition service funding, all the following must be present at the time the request is made:

- ☐ Individual is currently residing in a NF, ICF/IID, QRTP, PRTF, or hospital (excluding the State Hospital and other hospitals which are IMDs) at the time of service authorization;
- ☐ Individual has resided in the institution for a minimum of 30 consecutive days;
- ☐ An anticipated discharge date has been established;
- ☐ The individual will be discharged to a living arrangement in a private residence where he/she is directly responsible for his or her own living expenses;
- ☐ Individual will be receiving Medicaid or Medicaid Expansion upon discharge from the institution;
- ☐ Individual will have a federal poverty level of 150% or below upon discharge from the institution;
- ☐ Individual has a qualifying 1915(i) diagnosis;
- ☐ Individual has a WHODAS complex score of 25 or higher or a score of 5 or lower on the DLA; and
- ☐ Individual is reasonably expected to be eligible for and enroll in the 1915(i) within 90 days of the approval of the community transition service.

Individual Information		
Name (Last, First, MI):		
Date of Birth:	SSN:	ND Medicaid ID Number:
Name of Institution Individual Currently Resides:		
Admission Date:		Anticipated Discharge Date:
Discharge Address (*if known*):		
Case Manager		
Case Manager Name:		Agency Name:
Agency Address:		City:
State:		Zip Code:
Phone:		Email:
Diagnosis		**Diagnosing Professional Information**
Date of Diagnosis:		Name:
1915(i) Qualifying Diagnosis and ICD Code(s):		Title:
		Phone:
		Email:
WHODAS 2.0 - Domain Scores & Overall Complex Score		
Domain		*Score*
Communication		
Mobility		
Getting Along		
Self-Care		
Life Activities		
Participation		
WHODAS 2.0 - Overall Complex Score:		
Date WHODAS 2.0 Assessment Completed:		
Name of WHODAS Administrator:		
Daily Living Assessment (DLA)		
DLA – Overall Score:		
Date DLA Assessment Completed:		

Goal

In the individual's own words, identify their goal associated with the CTS:

Select the functional need from the WHODAS 2.0 assessment this goal helps to address (*select all that apply*):

- ☐ Communication
- ☐ Mobility
- ☐ Getting Along
- ☐ Self-Care
- ☐ Life Activities
- ☐ Participation

Select the functional need from the DLA this goal helps to address (*select all that apply*):

☐ Alcohol and drug abuse	☐ Dressing	☐ Money Management	☐ Relationships
☐ Behavioral norms	☐ Grooming	☐ Nutrition	☐ Safety
☐ Communication	☐ Health Practices	☐ Personal Hygiene	☐ Sexual Life
☐ Community	☐ Housing Stability	☐ Problem-Solving	☐ Social Networks
☐ Coping mechanisms	☐ Leisure	☐ Productivity	☐ Time Management

Does this individual require 1915(i) CTS funding to achieve this goal: ☐ Yes ☐ No

Service Information

Dollar Amount Requested:

Explain how the individual's need for the CTS is reasonable and necessary. Your explanation must rule out the individual's ability to pay for the necessary items and also rule out that another service is available to pay for the necessary items.

How will the CTS assist the individual with meeting their identified need(s)?

Service Approval Dates

Service Approval Begin Date (*Must be within 90 days of client's discharge)*:	Proposed Service Approval End Date *(Must be 180 days from begin date)*:

Actual Service Approval End Date:

This date is to be completed and the form re-submitted to Veridian when any of the following occur (*check all that apply*):

- ☐ It is determined the client will not be discharged to their own home.
- ☐ The individual has not been discharged by the end of the 90 day period.
- ☐ The individual has not been found eligible for the 1915(i) by the end of the 90 day period.
- ☐ The individual is not living in their own home by the end of the 90 day period.
- ☐ The maximum approved money has been spent.
- ☐ At midnight on the "end date" which is a maximum of 180 days since the begin date.

Note: All payments for purchases must be issued within the begin date and actual end date.

Signature Blocks

Individual Signature:

Date:

Parent/Legal Guardian Signature, if applicable:

Date:

☐ As the case manager completing this form, I agree to conduct discharge planning with the individual, complete all requirements associated with the community transition funding, and continue oversight until the duration of the CTS request has expired.
Case Manager Signature:
Date:
STATE USE ONLY
☐ Approve or ☐ Deny
Reason(s) for Denial:
Comment(s):
Signature of Authorizing NDDHS Staff:
Date: