Shared Case Policy; MFP Waiver, Demonstration & Rule 132 Services
MFP Shared Cases Policy and Procedures
Key Points

- Recognize that many/most participants present with a variety of physical, behavioral and mental health needs.
- Resources are available to you throughout the assessment and transition process to assist in identifying and addressing those needs.
- Think holistically about the participants’ capacity to function in environments with less support and less structure than the institutional setting in which they have lived, possibly for years.
- What are their strengths and what will be their challenges?
Initial Contact/Assessment

- Transition Coordinator (TC), or Transition Engagement Specialist (TES) in certain counties, completes initial contact, considers possible need for collaboration with another division, completes case note or, for the TES, a mini-assessment and a referral to the appropriate Division/Department TC.

- Participants with a diagnosis of a Severe Mental Illness (SMI) will always be assigned to a TC from Mental Health.

- TC determines membership in an MCO. If an MCO member, TC informs MCO of the member’s participation in MFP and includes the MCO Care Coordinator in the care planning process.

- TC requests Case Overview/Mini-Conference with UIC. Conference can be an informal call, a scheduled session, or an email. It includes MCO, if the participant is a member, and reviews basic issues identified at that point. Discussion during the Case Overview determines the need for collaboration and the appropriate Division/Department for that collaboration.
Case Collaboration

- TC contacts collaborating Division/Department and community agency staff and copies UIC, MCO, if appropriate, and Department lead.

- UIC establishes read-only CRM access which allows collaborating staff to upload documents such as assessments and case notes to the participant’s file.

- Identifying information – name, RIN, SSN, address – should not be included in emails. Use the MFP case number provided by the TC.
Collaboration may occur at any time throughout the assessment and planning process. Collaboration may include:

- Learning about the resources which will be available to the participant post-transition;
- Discussing the appropriate services; determining eligibility for community services;
- Evaluating the adequacy of the services, any gaps in service and ways to address those gaps;
- Identifying the timeframes required to complete any additional assessments for service and any possible delays in implementing the services.

A key component in collaboration is clear and thorough communication.

- Activities with the participant or on behalf of the participant need to be documented.
- Any significant change in the support system, health of the participant, participant’s behavior in the NF, housing preferences or other factors which may impact the transition planning should be documented.
- Documentation should be done in a timely way, within a week or two, if possible, in order for it to be most helpful for the other staff collaborating on the case.
Ongoing Collaboration and Staffings

- The TC, collaborating agency staff, and MCO staff shall all be included in staffings scheduled and coordinated by UIC staff. These include the pre-transition call, the 30-days post-transition call and any other calls needed, depending upon the participant’s circumstances and any changes in those circumstances.

- All involved in the staffings can contribute information which identifies risks which might jeopardize a successful, long-term transition to the community. The TC from the lead agency is responsible for including that information in the risk assessment and mitigation plan.

- UIC staff are available for consultation throughout this process. TCs can access this quality component by contacting the UIC scheduler for their Division/Department.
Case History of an MFP Shared Case

Thinking and Working Collaboratively and Holistically

Beth Weiss

Illinois Department of Health and Family Services
MFP–MH Case Review

- 52 year old male, admitted to nursing facility (NF) April, 2014
- Suffered stroke March, 2014; uses walker
- Receives SSI and Medicaid benefits; has a payee, but is his own guardian
- Has had a caretaker in the past who assisted him with ADLs
- Was evicted from last residence for inability to maintain living space
- Has outstanding utility bill
- Physical health issues: history of respiratory failure, shortness of breath, pneumonia, falls, chronic renal failure, cardio-vascular issues, diabetes, hypertension, anemia, has had a colostomy
- Psychiatric diagnoses in the record: Bipolar, Depressive Psychosis, Intermittent Explosive Episodes, history of alcohol abuse
- Transitioned to community February, 2015
Key Components of Interagency Collaboration

- 30+ case notes in CRM detailing face-to-face and telephone contacts with participant and collaborating agencies over a 6-month period

- Within the first two months, while MFP–MH TC is completing her assessment, contacts are made by the TC with the Case Manager at the Mental Health Center who will be working with the participant in the community. Discussions included:
  - Possibility of participation in Psychosocial Rehabilitation before NF discharge; payment of the outstanding utility bill; searching for an apartment; areas in which the participant would like to live and the participant’s finances.

- Ongoing MFP TC’s visits with the participant focus on:
  - Skills needed for life in the community (including following landlord’s rules and paying bills on-time); the importance of preparations now to prevent relapse; medication adherence and the need for in-home services.
Months Two – Five

- Face-to-face meeting with MFP TC, mental health agency case manager and participant re: Team support services, medication management, access to MD appointments
- Pre–Pre and Pre–transition staffings with UIC MFP–MH Team and MCO re: In–home services, current status, preparations for transition (MCO involvement was discontinued when participant became a “Dual.”)
- Multiple Contacts between Center for Independent Living and MFP TC re: Completion of a Determination of Need (DON), level of in–home service needs, service availability, appropriate independent providers (IPs) to meet the needs, hiring, scheduling, supervision and problem–solving with IPs, obtaining, assembling and ensuring the functionality of assistive devices, obtaining landline for EHRS
- Meetings with NF social worker to receive updates re: participants’ status
- Outreach to Visiting Nurses Association (VNA) for colostomy care, contact with MD for the order for VNA
Month Six and Beyond

- Maintaining intensive ongoing wrap-around services
- Communication between all involved
- Anticipating, thinking holistically
- Trying to coordinate the unexpected!
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Mental Health and Mental Health Services

Charlotte Kauffman, M.A., L.C.P.C
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Illinois Department of Human Services
Mental Illness

A medical condition that can disrupt a person’s

- Thinking
- Feeling
- Mood
- Ability to relate to others
- Daily functioning
Classes of Mental Illness

- **Mood Disorders** – Affect how you feel emotionally
  - Depression
  - Bipolar Disorder

- **Anxiety Disorders** – emotion characterized by the anticipation of future danger or misfortune, plus feeling ill at ease
  - Generalized Anxiety Disorder
  - Panic Disorder
  - Obsessive Compulsive Disorder
  - Phobias
  - Post–Traumatic Stress Disorder

- **Substance Related Disorders** – Including use of
  - Alcohol
  - Legal drugs – including medications
  - Illegal drugs
Psychotic Disorders – cause detachment from reality. Examples:
- Schizophrenia
- Schizoaffective
- Psychotic Disorders NOS

Cognitive Disorders – affect your ability to think and reason
- Delirium – Temporary decreased awareness of one’s environment and confused thinking
- Dementia – impaired thinking and social abilities enough to interfere with daily functioning
Facts on Adults with Mental Illness

- 1 in 4 experience mental illness in a given year
- 1 in 17 live with a serious mental illness such as schizophrenia, major depression and bipolar disorder
- 26% of homeless staying in shelters and 46% of all homeless live with severe mental illness and substance use disorder
- 20% of those incarcerated (jails & prisons) live with severe mental illness
Hospitalizations
  ◦ Depression 3rd most common cause

Increased risk of chronic medical conditions
  ◦ Adults with serious mental illnesses die on average 25 years earlier

Many are preventable
  ◦ Suicide 10th leading cause of death (more common than homicide)

Suffering – immeasurable
Common Symptoms You May See

- Feeling sad or down
- Confused thinking/Unable to concentrate
- Excessive fears or worries
- Extreme mood changes: highs/lows
- Withdrawal from friends, activities, interests
- Detachment from reality
- Delusions, paranoia, and hallucinations
Common Symptoms You May See (cont.)

- Inability to cope with daily problems/stress
- Extreme feelings of guilt
- Major changes in eating habits
- Major changes in sleep patterns
- Sex drive changes
- Excessive anger, hostility, violence
- Suicidal thinking
A Brief Overview of Illinois’ Publicly Funded Community Mental Health System

Two Central offices:

- 401 S. Clinton Street, 2nd Floor, Chicago 60607
- 319 E. Madison, Suite 3B, Springfield, IL 62712

Five Regional Offices:

- Chicago: Region 1 – North, Central, South
- Region 2 – Northwest Suburbs
- Region 3 – North Central
- Region 4 – Central
- Region 5 – Southern Part of the state
DHS/DMH contracts with over 158 Community Mental Health Providers

DMH Funded Services

- Medicaid ("Rule 132" Services)
- Crisis Intervention
- Mental Health Assessment/Treatment Planning
- Medication Services
- Community Support/Skills Training
- Assertive Community Treatment
- Individual and Group/Therapy/Counseling
- Case Management
- Psychosocial Rehabilitation
Some of the Grant Funded Services/Programs:

- Crisis Capacity
- Psychiatric Leadership
- Psychotropic Medications
- Residential Capacity
- Permanent Supportive Housing
- Juvenile Justice
- Individual Placement and Supports
- Community Conditional Release Program
- Peer Support Services
- Prevention – Mental Health First Aid
Other Supports Are Available

- **Community Support Groups**
  - Alcoholics Anonymous, Narcotics Anonymous
  - Depression and Bipolar Support Alliance (DBSA)
  - National Alliance for the Mentally Ill (NAMI)
  - Emotions Anonymous
  - Local Consumer–Created Groups
  - GROW in America
  - Community Advocacy Groups

- **Family, Friends, Peers**

- **Churches**

- **Junior Colleges**

- **Medical Community, Pharmacists**
Sometimes what is needed most in difficult times is someone to talk to. The Illinois Mental Health Collaborative for Access and Choice’s Warm Line is available for persons with mental health challenges and their families to receive support by phone. The warm line is not a crisis hotline, but is a source of support as individuals and families recover.

Call: 1 (866) 359–7953
TTY: 1 (866) 880–4459

Hours of Operation: Monday through Friday, 8 A.M. except holidays. From the main menu, select option #2 for Consumers and Families. Next, select Option #5 for the Warm Line: Peer and Family Support by Phone.
Copy of ACT CST Providers – 4.10.15.xlsx
Copy of Provider Directory – Region – 1–13–15.xlsx
Rule 132.pptx
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These services include: Comprehensive Care Coordination, In–Home Care, Adult Day Care and Emergency Home Response, as well as other services which are mandated under Titles III and V of the Federal Older Americans Act (OAA) such as: transportation, housing, home delivered and congregate meal service, support to senior centers, and senior employment services.

In FY 15: Average monthly caseload of Community Care Program—82,600 seniors.
Adult Day Service is the direct care and supervision of adults aged 60 and over in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting.

*The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit.

*Rate: $9.02 per hour.

*Payment during any month is limited to a maximum of 115 hours.
ADS Transportation to and from Adult Day Service.

*No more than two units of transportation shall be provided per participant in a 24-hour period, and shall not include trips to a physician, shopping, or other miscellaneous trips.

*Rate: $8.30/one-way trip.
Elderly Waiver Services: Case Management

Case Management

*Includes services that assist participants in gaining access to needed MFP, waiver and state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services.

*Responsibilities include assessment, care plan development and ongoing monitoring and review.

*Rates:
Face-to-Face Pre-screen ($89.53);
Deinstitutionalization Assessment ($248.08);
Initial Assessment ($142.73);
Reassessment ($107.07);
Intensive Casework ($190.32); and
Intensive Case Monitoring ($118.15).
In–Home Services are defined as general non–medical support by supervised and trained In–Home Care Workers.

*In–Home Care Workers are trained to assist individuals with their activities of daily living, including personal care, as well as other tasks such as laundry shopping, and cleaning.

*The purpose of proving this service is to maintain, strengthen and safeguard the functioning of MFP participants in their own homes in accordance with their authorized plan of care.

*The amount, duration and scope of services is based on the determination of need assessment conducted by the care coordinator and the service cost maximum.

*Rate: $17.14/ hour.
Personal Emergency Response System (PERS) is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency.

*Installation: $30.00/one time.

Monthly Rent: $28.00
Supportive Living Facilities (SLFs) are an affordable assisted living model administered by HFS that offers *frail elderly housing with services. (*Most SLFs required that the participant be are 65 or older).

Rates: Rates are established at 60% of the nursing facility rate for the geographic region.
Community Based Services
Older Americans Act Programs

- The Department funds a wide range of services with Title III of the Older Americans Act (OAA) Federal funds and State GRF through grants to the 13 Area Agencies on Aging.

- These services address needs of senior citizens in four areas:
  - Accessing services (e.g., information & assistance; transportation, and outreach);
  - In–home services (e.g., Home Delivered Meals);
  - Community supportive services (e.g., congregate meals, legal assistance, health promotion); and
  - Caregiver services (e.g., respite, information & assistance, counseling and support groups).

- All persons age 60 and over and their caregivers are eligible for services under the OAA, although preference is given to those in greatest economic or social need, low–income minority older adults, those with limited English proficiency, and older adults residing in rural areas.
Nutrition Services

- A national evaluation documented that elderly nutrition programs effectively targets services to vulnerable older adults who are older, poorer, at higher nutritional risk, more functionally impaired, more likely to live alone, and more likely to be a minority member than the general U.S. population.

- Nutrition service providers use funding from a variety of sources to produce meals for older persons aged 60 and older in Illinois. Sources of funding include: federal Title III funds, state GRF, local match, client contributions, and federal Nutrition Services Incentive Program funds. The meals produced from these funds are consumed at senior centers or meal sites (Congregate Meals) or in the home (Home Delivered Meals).

- The profile of the meal recipients are similar in age, as 64% of HDM clients are 75+ and 54% of CM clients are 75+. The percentage of recipients aged 60 and older at or below the poverty line is 45% for HDM and 30% for CM. 78% of the HDM recipients aged 60+ have 3 or more ADLs.

- In FFY10, over 140,533 persons aged 60 and older were served by the nutrition program and over 10.4 million meals were produced. Of that total, about 7.6 million meals were home delivered to about 40,900 persons.
Senior Employment Specialist Program (SESP)

- State GRF funds for the SESP program are awarded to the 13 Area Agencies on Aging (AAAs) to help support an FTE position at the AAA to help promote employment opportunities for all persons over age 55.

- The AAA Employment Specialists are challenged to work with the local employment one-stop centers as well as trying to help with the employment needs of older persons ineligible for the Federal Title V training program which in FY 12 had 358 slots for IDoA to administer.

- At the beginning of FY12, the Department had 622 participants enrolled on the Title V program.
Planning and Service Grants, Community Based Services (CBS); and CBS – Equal Distribution

- The Area Agencies on Aging also receive state funds from three (3) GRF lines to augment the federal Title III funds they receive for supportive services delivered to older persons in the community.

- These funds are used for the following community based services:
  - case management,
  - assisted transportation,
  - information & assistance,
  - outreach,
  - respite
  - transportation,
  - chore housekeeping,
  - residential repair & renovation,
  - legal assistance,
  - multipurpose senior centers, and
  - congregate meals.
Grandparents Raising Grandchildren (GRG) Program

- Created through a two-year Brookdale Foundation grant in October of 1996, the GRG program provides funding to Area Agencies on Aging (AAAs) and non-profit organizations to address the needs of relatives raising children.

- Funds are requested to establish and maintain statewide support groups; provide emergency assistance; counseling; legal and housing assistance; respite; outreach and education; and allow AAAs to assist relatives under the age of 55 who are not eligible to receive help through the National Family Caregiver Support Program.

- Over 213,000 children are living with 100,000 relatives in Illinois with no agency formally identified as their avenue to benefits, advocacy and assistance. The Department fills that role by collaborating with DCFS, DHS, ISBE and HFS to assist relatives navigate the system and to advocate on their behalf. Since the program’s inception, over 3,000 relatives have contacted the Department for assistance.
Retired and Senior Volunteer Program (RSVP) & Foster Grandparent Program (FGP)

- The Department provides state funds for non-federal match requirements for the Retired and Senior Volunteer Program (RSVP) and Foster Grandparent (FGP) projects operated under the Federal Corporation for National Service’s Senior Services Corps.

- These programs are unique and distinct from most older adult programs by utilizing seniors as a resource to help communities fill unmet needs; promote volunteerism, learning and intergenerational activities.

- In FY10, over 15,400 RSVP and FGP senior volunteers provided more than 3.4 million hours of service.
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Community Reintegration Program
Money Follows the Person Program

Paving the Way to Community Living
Community Reintegration:

- Community Reintegration is the opportunity for qualified customers, residing in long term care facilities, to receive Home and Community Based Waiver Services as an alternative to nursing home placement.
- Community Reintegration is a service that provides an option for persons age 18–59 to experience community living through self directed and cost effective home care. The service is intended to be a one–time process.
Community Reintegration customers are eligible to receive a service package designed to meet their individual needs in the community and may include:

- Personal Assistant
- Home Delivered Meals
- Homemaker
- Emergency Home Response
- Adult Day Care
- Maintenance Home Health
- Assistive Equipment
- Environmental Modification
Community Reintegration: (continued)

- In addition, upfront monies to purchase goods and services for independent living, such as initial supply of groceries, household furnishings, cleaning products, and personal hygiene items. Without these core services, persons with disabilities would continue to inappropriately remain in long term care facilities throughout Illinois.
DRS contracts with 23 Centers for Independent Living, known as CILs, to provide reintegration services.

Referrals come to the CILs from a variety of resources, many generated by community outreach:

- Nursing Homes
- DRS field staff
- Self referral
- Medical community
- Other state and local agencies and
- Community referrals
Illinois Network for Centers for Independent Living
CILs are non-residential community service agencies that provide such services as:

- Peer Advocacy
- Peer Support
- Information and Referral
- Independent living skills training
CILs also provide other services to meet the needs of people in their communities, such as:

- Personal Assistance Programs
- Job Readiness Training
- Youth Programs
- Services to Persons who are Deaf or have Visual Impairments
Transition Coordinators, employed by the CILs, provide reintegration services to individuals with physical disabilities, excluding persons with severe mental illness.

Transition Coordinators also provide information to any participant regarding:

- Local resources
- Disability issues
- Assistive technology
- Home modifications
Independent living is the right of people with disabilities to control and direct their own lives, to have choices and options, and to actively participate in all aspects of society. Community Reintegration Program, known as CRP, and Money Follows the Person, known as MFP, are two programs designed to reintegrate individuals between the ages of 18 & 59 who are interested in moving back into the community from a nursing facility.
Two Programs – One Goal – Independence:

- CRP is designed to reintegrate individuals back into the community from a nursing facility setting. Funded by Illinois DHS/DRS and the Illinois Housing Development Authority, CRP is able to provide services and purchase items to establish a home in the community. This program is partially reimbursed by Medicaid. The goal is to identify the services and support systems the individual will need in order to live independently.
Money Follows the Person (MFP) is sponsored by the federal Centers for Medicare and Medicaid Services (CMS). All services through the CRP program are available to MFP recipients. MFP is part of a statewide, multi-department demonstration program. The goal is to identify the services and support system the individual will need in order to live independently.
Community Reintegration Program: CRP

- Receives or have applied for Medicaid
- Complete a DON
- Have resided in a nursing home
- Eligible for use of Upfront Funds/Waiver services
- Age 18–59 (exception for TBI or HIV/AIDS)
- Consumer transfers from CIL to HSP office after up to 1 year post discharge from the nursing home
Community Reintegration Program: CRP

- Consumers scoring under 29 points on the DON are allowed to utilize Upfront Funds only
- Resides in a nursing home
- No waiver services
- Age 18–59
Upfront Funds:

- Provided and used for services such as:
  - First/last month’s rent
  - Home modifications
  - Groceries
  - Household furnishings
  - Personal assistant services
  - Assistive equipment and devices
Let’s review CRP:

- Individual needs to be on Medicaid or submit an application to be on Medicaid
- Score at least 29 on the DON to receive home care, but can receive up-front funds to transition if DON score is less than 29 points; there is no minimum DON score required in order to participate in CRP
- In Nursing Facility less than 90 days
- Ages 18–59, unless TBI or HIV/AIDS
- CILs retain case management for up to 1 year post discharge from the nursing home. For those scoring under 29 on the DON, CILs retain case management for up to 3 months post discharge from the nursing home.
Money Follows the Person (MFP):

- Must be a Medicaid beneficiary/recipient
- Scored over 29 on the DON
- Must have resided in a qualified institution, such as a nursing facility, for at least 90 days
- Must be between the ages of 18–59
- CILs retain case management for up to 1 year post discharge from the nursing facility
Both Programs save the state millions of dollars every year in nursing home costs.
Case Management with CIL/TC ends; but living independently in the community continues:

- Throughout the reintegration process, the CIL Transition Coordinator has been providing face-to-face follow up, particularly after a critical incident, and telephone contact with the participant. During that time, all areas of concern are addressed and necessary training provided to ensure a successful transition into the community. When the participant has successfully transitioned, it is time to transfer the CRP/MFP case to the field office.
Transferring CRP/MFP cases: (cont.)

- Once an individual successfully completes the 3 months or up to 1 year post discharge from the nursing home to CRP or MFP, the case is then transferred to the Region where the individual resides. This is done with the focus on efficiency and effective customer service. To that end, it is encouraged that the Counselor and CIL Transition Coordinator schedule a joint visit with the participant. Working in collaboration, the Counselor and Transition Coordinator can discuss the current scope of services based on
A multitude of factors such as mental status and level of awareness, the customer’s ability to function independently in the performance of ADL’s, and possessing the skills to follow directions from a physician, nurse, or therapist as needed for routine health care.
Community Reintegration Staff:

- Stacey Bolin, Program Service Advisor, CRP/MFP
  (217) 557–1169

- Nathan Harmon, HSP Coordinator, CRP
  (217) 524–5489

- Linda Gonulsen, Manager, CRP/MFP
  (217) 785–7639
Seeing is believing:

- It is important to read, study, understand processes and procedures, rules and regulations, and know of staff who you can contact with questions for any program.
- However, and I am sure you have experienced the feeling, when the puzzle pieces begin to fit, the services and support systems are in place, and the individual is experiencing an independent lifestyle again….seeing is believing.
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Eligibility Criteria
What is a Developmental Disability?

A person with an **intellectual disability or a related condition**.

**Intellectual disability** – The following must be met:

- Manifests BEFORE age 18;
- Results in sub average general intellectual functioning (i.e., IQ of 70 or below); and
- Exists concurrently with deficits in adaptive behavior.
Related condition is a severe, chronic developmental disability that meets all of the following criteria:

- Attributable to cerebral palsy, epilepsy, or any condition other than mental illness found to be closely related to an intellectual disability.
- Results in impairment similar to an intellectual disability and requires similar treatment or services.
- Manifests BEFORE age 22 and likely to continue indefinitely.
- Results in substantial limitation of function in 3 or more major life activities:
  - Self-care
  - Language
  - Learning
  - Mobility
  - Self-Direction
  - Capacity for Independent Living
- The above limitations must be related to the developmental disability, NOT to other conditions such as health issues, emotional disorders, substance abuse, or personality.
Illinois DDD Service System Serves over 44,200 persons

412 privately operated service providers

- Community Integrated Living Arrangements (CILAs)
- Day and Vocational Services
- Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/DD)

7 State Operated Developmental Centers (SODCs)
Individual Service Coordination Agencies

- Provide advocacy assistance, ensure official diagnosis of developmental disability, identify services needed, determine eligibility for Medicaid Waiver services, complete Ligas Transition Plan with class members.

- Assist persons with the choice process, send referral(s) to service provider(s), assist service providers with funding requests for submission to DDD, conduct on-site monitoring for 4 weeks after initiation of Medicaid Waiver–funded services and quarterly thereafter.

- There are 18 Individual Service Coordination Agencies (ISC) throughout the state and their agents perform the TC duties for those participating in MFP.
Prioritization of Urgency of Need for Services (PUNS)

- PUNS form and database implemented November 2004 as mandated by PA 93–0503.
- PUNS data used for planning and authorizing DD services, as well as advocating for expanded DD funding for services when available.
- ISC agent meets with persons who are reasonably believed to have a developmental disability and their guardians/families in person to identify need for services and the urgency of that need.
- PUNS form is completed and the information is entered into data system
More than 44,225 persons have been enrolled in PUNS as of May 4, 2015, and of those, more than 22,928 are still currently seeking services*

As of June, 2015 95 Ligas Class Members and 106 individuals from SODC’s have transitioned as MFP participants since January, 2014

*http://www.dhs.state.il.us/page.aspx?item=56039
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