Policy: It shall be the policy of the Division to support citizens who have mental retardation and related conditions to exercise the same rights to state services as all residents of Nevada, including the right to services in or near their community of residence, close to family members, and in their community of choice.

Purpose: Transfers of individuals between Regional Centers shall be conducted in a manner that will maintain continuity of services, respect personal choice, and maintain and expand natural support networks.

Definitions:

- Residency: The residence of a minor child will be the state where the child's parents reside or the location of other guardians or agencies having legal custody. The residency of an adult will be determined by where they live or by the state providing support services to the person. Persons placed out of Nevada by a Nevada agency and supported by a Nevada agency will be considered residents of Nevada.

Procedures:

I. Transfers between Nevada and Other States

A. All requests for services in Nevada will be referred to the intake coordinator of the appropriate regional center.
   1. For minor children, application will be made to the regional center serving the area of the parents/guardians legal residence.
   2. For children in the custody of a Nevada agency, application will be made to the intake coordinator of the regional center serving the area in which the agency with custody is located.
   3. For adults who are out-of-state residents, application will be made to the regional center serving the area to which the adult wishes to move.

B. Applicants for DS services can be assessed for service eligibility prior to moving to Nevada. This can be done by any region and requires that the individual or guardian submit all materials necessary to make a determination of eligibility.

C. A case can be opened for an adult once the person has physically moved to Nevada and established Nevada residency. At that time the person will be assigned a service coordinator by the region of residency.
   1. The person in conjunction with their service coordinator will establish a support plan.
   2. The person may be placed on appropriate waiting lists with their date and rank on the lists determined by the time they establish residency and developed a support plan identifying the service need.

D. If the child or adult lives in an out of state facility, requests for transfer to

Nevada shall be addressed once the child or adult has an open case with a DS agency and an assigned service coordinator. The assigned service coordinator will assist the person, parents/guardian or custodial agency to contact the agency directors and Nevada Medicaid to find out about availability of placements and waiting lists.

E. Adult residents of facilities in other states will be considered legal residents of that state. It is not necessary to pursue their transfer to Nevada unless it is the request of the individual or their legal guardian due to their desire a transfer to Nevada to maintain family involvement.

F. If the legally responsible parent/guardian of a child moves to another state and establishes residency there, they will be required to seek placement of their minor child in the new state of residency within 90 days. The service coordinator will provide assistance for the family to get in touch with the relevant agencies, including Medicaid, and make information available to assist with the transfer.

G. Regional Center Directors must receive written permission from the Division Administrator prior to approving any out-of-state transfer to an ICF/MR or other care facility for a Nevada resident.

H. Transfers for a person shall be handled in an expedient, efficient, and consistent manner so as to alleviate the attendant anxiety inevitably caused by these transfers. The Division is responsible for any open case and assumes the full cooperation of DS agencies with each other and with the Division in these cases.

II. Transfers between Nevada Regional Centers

A. Should a resident of a Nevada ICF/MR facility be discharged, there must be provision for appropriate services in the resident's new environment, including appropriate protective supervision and other follow-up services. The parents/guardians are to be involved in discharge planning as partners, not as primary planners.

B. A minor whose legal guardian resides within a regional area shall receive supports from the regional center that serves the area where the guardian is located, even if the child is placed in a community served by a different regional center. Once the person reaches the age of majority the decision to transfer to another regional center for services will be based on where the individual wishes to live.

C. When a person (or family with a minor child) wishes to move to an area served by a different Regional Center, the service coordinator will complete the following:

1. The person's service coordinator will notify their regional intake coordinator of the intended move. Intake coordinators from both regions will be responsible for coordinating the exchange of information up until the time the transfer to a new service coordinator is completed. Service coordinators shall not contact intake coordinators of other regions directly to request a transfer.
2. The service coordinator is responsible for assuring that provisions of this policy are followed and that informed consent for the move is made based on experiences and education in the new community.
3. The service coordinator will work with their intake coordinator to provide a comprehensive packet of information to be sent to the intake coordinator in the receiving region. The packet shall include, but is not limited to:
    a. Most recent copy of the ISP;
    b. Face sheet;
    c. Copy of 2734 showing Waiver start date (if applicable);
    d. Current social assessment;
    e. Current nursing assessment;
    f. Copies of current service contracts;
    g. Medicaid and benefits;
    h. Desired services and information used in determining eligibility. Minimum eligibility information shall include both cognitive and adaptive assessments, educational testing and the Assessment Cover Sheet for Mental Retardation and Related Conditions.
4. The service coordinator and team will assist an adult to visit the new community and learn about available options prior to finalizing his or her decision to move, if possible. The person will be encouraged to experience options through visits or discussions with providers and people served.

D. When the intake coordinator of the receiving region receives notice that a person is moving, he or she will:
1. Notify their agency IT staff to modify the person's DS-NOW access to allow notes from both regional center staff during the transition process.
2. Notify their Agency Director or Director of Community Services of the proposed transfer.
3. In conjunction with community services staff provide information to facilitate visits and knowledge of options for services in the new community.

E. Coordination of Services for Waiver Participants:
1. The person's service coordinator is responsible to assist the person to choose a waiver provider(s) in their new location prior to their move.
2. The intake coordinator of the receiving region will provide information about who to contact for information about available services in the new community.

3. All service contracts will be reviewed, updated as needed, and agreed upon by responsible staff of both the referring and receiving regional center prior to the move.
4. The referring service coordinator will assure that all necessary information about address changes, change in Waiver status, etc. is shared with funding agencies, such as Medicaid, to assure continuity and security of resources.

F. Payment for Waiver Services:
1. If funding is not immediately available for the person's services in the new region, the original Regional Center shall continue to pay for services in the new region until funding becomes available, but no longer than six months.
2. Waiver participants will go to the top of waiting lists for services in the new region.
3. The Director or designee will consult with the Director or designee of the original region to determine a target date for the new regional center to take over payment for waiver services, within 6 months of the person/family's move.

G. Funding for Non-Waiver Services:
1. The person's service coordinator will check on availability of funding in the new community. If there are waiting lists for services in the new region, the service coordinator will inform the person/family that they will have to go on the waiting list in the new region once they move. The person's service coordinator is responsible for clarifying expectations for services and funding once the move occurs.
2. The new service coordinator will assist the person or family to access needed services. If there is a waiting list for any services requested by a non-Waiver participant, the intake coordinator will place the person's name on the waiting list(s),

H. Service Coordination Transfer and Billing:
1. When the person has a target date for moving, the intake coordinator will forward the record to the supervisor for assignment to a new service coordinator. The new service coordinator will notify the original service coordinator of their assignment.
2. The service coordinator will notify IT when the person physically moves to the new community. IT will assure both regional centers can access DS-NOW notes until the case is officially closed.
3. Once the person has moved, the original service coordinator will code his or her case notes as non-billable ("99") and the new service coordinator will use billable TCM codes in DS-NOW.
4. The new service coordinator will conduct an ISP meeting to review goals, services and supports within 30 days of the person's move

I. Case Closure and Completion of Transfer:

The person's case will be closed at the referring Regional Center after financial responsibility is transferred or 30 days from the move date following the ISP. The service coordinator will notify IT to close the case in DS-NOW.

III. Each DS agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency policy manual.

Administrator

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