DIRECT CARE AND TREATMENT

Long-Term Services and Supports

Standard Operating Procedures for Individuals in Direct Care and Treatment Facilities

07/29/2026

Direct Care and Treatment Contact Information

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Upon request, this material will be made available in an alternative format such as large print, Braille, or audio recording.

Project Background

In February 2024, Direct Care and Treatment (DCT) launched an Incident Command System (ICS) to accelerate discharges from DCT facilities, with an initial focus on the Anoka-Metro Regional Treatment Center (AMRTC). One of the critical areas identified was the need to standardize and streamline Long-Term Services and Supports (LTSS) processes to reduce discharge timelines and ensure that all partners were working efficiently and collaboratively to support successful transitions to the community.

To address this need, a cross-system workgroup of county Targeted Case Management (TCM), Long-Term Services and Supports (LTSS) leadership from Hennepin and Ramsey Counties, and DCT staff developed the first iteration of a Standard Operating Procedure (SOP), flowchart, and training materials. A second short-term workgroup was formed in late 2025 with support from the Minnesota Association of County Social Service Administrators (MACSSA). This group included Targeted Case Management and LTSS leaders from Anoka and Nicollet Counties, along with DCT staff, and was charged with assessing the end-to-end LTSS process and recommending enhancements and best practices. In January 2026, a third workgroup, focused on children and adolescents, with representation from Anoka, Hennepin, and Dakota Counties. Recommendations from these workgroups were presented to MACSSA's Adult Services and Children's Mental Health Committees for review and endorsement. This SOP and the associated training materials will be reviewed annually and update critical content with the same core representatives that created it.

Strong collaboration among DCT, counties, and community partners is essential to ensure that individuals receive the appropriate level of care and support in the most integrated setting possible. Through shared planning, aligned expectations, and coordinated funding and authorization processes, partners can ensure that individuals are placed in settings that meet their unique clinical and functional needs. Effective collaboration also supports efficient use of public resources, reduces unnecessary delays in placement, and promotes timely access to services that support stability, recovery, and long-term community living.

Purpose and Scope of This SOP

This Standard Operating Procedure (SOP) is intended to capture common expectations across Direct Care and Treatment (DCT), counties, and community partners, support clear and consistent communication, and establish shared understanding of roles and coordination responsibilities. This SOP does not attempt to standardize statutory, financial, or county-controlled processes, which are governed by federal and state law, county policy, and local operational structures.

Variability across counties, waiver types, and individual circumstances is expected and appropriate. Accordingly, this SOP defines who is responsible, when coordination must occur, and how issues are escalated, rather than prescribing uniform procedures for how each county or agency must carry out its statutory duties.

Guiding Principles

The guiding principles for this project emphasize that we are one collective team working together effectively to support a common goal of transitioning individuals from a direct care treatment site to the most integrated setting. Clear and ongoing communication is crucial to the success of this endeavor, as it ensures that all team members are aligned and working collaboratively towards achieving the common goal.

As part of our commitment to effective communication and collaboration, attending treatment team meetings is essential to ensure that we are all on the same page and working together towards the common goal of transitioning individuals to the most integrated setting. These meetings provide a platform for sharing updates, discussing challenges, and developing strategies to overcome barriers in the transition process.

When facing barriers or challenges along the way, it is important to run them up through our respective chain of commands. This escalation process ensures that issues are addressed at the appropriate level and that necessary support and resources are provided to overcome obstacles in the transition process.

Additional guidance about these principles can be found in the frequently asked questions below.

Links to LTSS Tools and Resources:

- MnCHOICES Partnerlink
- Community-Based Services Manual (CBSM) - When a County of Residence completes MnCHOICES Assessment for the County of Financial Responsibility (CFR)
- Seniors applying for Medical Assistance (MA) / Minnesota Department of Human Services
- Printable application forms for health care programs / Minnesota Department of Human Services
- County and Tribal Nation Agency Address and Phone Number [DHS-5207]
- MnCHOICES Interagency Contact Point (MICP) List
- MnCHOICES / Minnesota Department of Human Services
- Determining County of Financial Responsibility
- Combined Application Form (CAF) [DHS Form 5223]

Roles and Responsibilities

The guidance below outlines what each of the key players roles and responsibilities at each phase of the episode of care to ensure funding and eligibility processes move effectively and efficiently. This is not an all-encompassing list of all steps taken.

Key roles and a summary of responsibilities include:

DCT Roles

- DCT Social Worker: Leads discharge planning coordination; assist client with the completion of forms and routes to the TCM for submission; requests assessments; refers for MnCHOICES assessment; coordinates psychosocial supports and care plan; arranges transport; compiles records; initiates post-discharge referrals; tracks county made referrals; collaborates to find placement.
- DCT Financial Counselor: Reviews financial information and eligibility; cost-of-care determinations.
- DCT Competency Attainment Services: Works closely with DCT Social Work and Discharge Planners to confirm 611 legal statuses, determine and assist with resolving potential barriers to discharge including bail conditions and conditional release order needs, files 5-day discharge notices, coordinates with the court as required. reviews bail conditions and completes notification of discharge recommendations agreed upon by the treatment team and county in the EHR.
- DCT HIMS: Health Information Management Services produces medical records; sends Transitional Care Record.
- DCT General Councils Office: Provides DCT legal guidance; consults with other legal entities; aligns with court.

County Roles

- County Targeted Case Manager (TCM): Reviews bail conditions; coordinates community support; consults with LTSS team regarding waiver needs; responsible for navigating county-specific submission processes; participates in treatment team; collaborates to find placement. Note: This could be an individual contracted to do work on behalf of the county.

  Note: For child and adolescent admissions, who serves as lead may vary based on who has treatment authority, and in some counties, the same individual may serve in multiple roles. Potential roles within targeted case management in Children and Family Services include, but are not limited to, the following (not all roles may be indicated depending on the case, and titles may vary by county):

  - Children's Mental Health Case Manager
  - Adoption Worker
  - Corrections or Juvenile Justice case Manager
  - Child Welfare or Child Protective Services (CPS) Worker
  - Indian Child Welfare Act (ICWA) Worker: The tribal ICWA worker always serves as the lead when the case is identified as an ICWA case.
- LTSS Team: For the purposes of this document, *LTSS* is used as umbrella term to also include Home and Community-Based Services (HCBS) waivers. As such, roles and responsibilities may vary based on the needs of the individuals and their eligibility, however, generally function as follows:
  - Host County LTSS Team (COR): Completes MnCHOICES assessment, shares results, and forwards them to the County of Financial Responsibility (CFR) LTSS Team.
  - CFR LTSS Team: Confirms CFR; conducts eligibility for waiver processing; shares outcomes; authorizes waiver services.
  - CFR County Eligibility Worker: Processes MA-LTC application & Asset Verification System (AVS); rate agreement; determines eligibility.

    - County Financial Case Worker or Waiver Case Manager: Reviews financial information and eligibility on behalf of the county responsible, files petition in county's district court.
- County Legal Resources: Provides County legal guidance; consults with other legal entities; aligns with court.
- Judge: Reviews and decides Notice of discharge.

Others

- Guardian: Acts as the legal decision-maker for the individual when the individual is a minor or lacks capacity to make certain decisions independently. For adults, the guardian's authority and responsibilities are defined by court order and state statute.

Overview of the Funding and Eligibility Process

Admission – Setting a Solid Foundation for LTSS Upstream

It is important for DCT, TCM and the LTSS team (CFR) to come together at the time of admission to plan for discharge. This allows for a coordinated and seamless transition of care for the client. By collaborating early in the admission process, all parties can work together to develop a comprehensive discharge plan that addresses the client's specific needs and ensures a smooth transition to the next level of care. It is essential that all key parties who are supporting the individual are identified at the time of admission. Where are multiple case managers involved, it also essential to identify who serves as the lead for communication and placement authority. It also allows for any necessary arrangements and needs to be addressed proactively, reducing the risk of complications or gaps in care during the transition. As with all stages, effective collaboration and communication amongst all stakeholders are crucial to establish a connection and determine the best way to support a client.

The key roles and responsibilities of different team members in this phase are as follows:

1. **DCT Social Worker or Discharge Planner:** The DCT social worker or discharge planner plays a key role in connecting all stakeholders together during the admission phase. They facilitate communication and coordination (routing) among team members, including the TCM, the county LTSS (CFR) worker, and the DCT Financial Counselor. They will request that assessments are sent to the TCM right after admission and ongoing as assessments are updated. Please ensure the client's professional support is accurately reflected in the patient contact information form.

   In the event a TCM has not been assigned at the time of admission, please reach out to county of financial responsibility for assistance. Specific to Dakota, Hennepin, and Ramsey please reach out to:

   - **Dakota:**
     - Adults — Mary Hennen at Mary.hennen@co.dakota.mn.us
     - Children and Familes — Kelly Ruiz at kelly.ruiz@co.dakota.mn.us
   - **Hennepin:**
     - Adults — Krista Nielsen at krista.nielsen@hennepin.us
     - Children and Familes — Sarah Elrashidi at Sarah.Elrashidi@hennepin.us and Jennifer Infanger at Jennifer.Infanger@hennepin.us
   - **Ramsey:**
     - Adults: — Kyle Davis at kyle.davis@ramseycountymn.gov
     - Children and Families: — Misty Williams at misty.williams@ramsey.mn.us

   a. **At Forensic Services:** the DCT social worker is responsible for reviewing the insurance eligibility and submits the cost of care determination to ensure that financial aspects are addressed appropriately.
   b. **At AMRTC:** insurance eligibility is verified by the financial counselor who initiates cost of care and assigns it to social workers to obtain signature. For CABHH insurance eligibility is completed by the financial counselor. The cost of care initiated by nursing, and social work assures its completion.
   c. **At CBHH, CARE and MSHS (IRTS facilities):** The intake worker verifies insurance eligibility.

2. **Targeted Case Manager:** Recognizing that TCMs may have limited history working with the client at the time of admission, any details the TCM may have about what is important to and for the client, the client's psychiatric baseline, and other pertinent information are most helpful to be shared with the treatment team to help guide the client's care and support plan. It is expected that the TCM attends all treatment team meetings, and touch base with the LTSS CFR team for consultation as needed. The TCM's role with respect to coordinating long-term services includes:

    a. Determine whether the waiver case is open.
        i. If yes, contact the waiver case manager to begin planning
        ii. If not, then refer to the **Treatment and Discharge Planning** section for additional guidance.
    b. Review Medical Assistance status;
        i. If there is no medical assistance, coordinate within internal CFR for medical assistance and complete necessary forms with the client and submit (as necessary).
    c. Notify/respond to CFR LTSS team, as soon as waiver residential services is being considered.
    d. Review CFR status to determine accuracy in consultation with CFR LTSS team. For adults served by Hennepin and Ramsey County, any CFR disputes should include:

        Hennepin: hsph.ltss.ia.bhi.supervisors@hennepin.us and krista.nielsen@hennepin.us

        Ramsey: RCMNChoices.Intake@co.ramsey.mn.us

3. **DCT Competency Attainment Services (CAS):** responsible for integrated work between other DCT key roles and the CAS team.

4. **DCT Financial Counselor:** The DCT Financial Counselor is responsible for submitting a change of status to the DHS-Institution of Mental Disease (IMD) team for individuals admitted to Forensic Services and Anoka Metro Regional Treatment Center (note: IMD processes do not affect other sites). As previously mentioned in this document, the Financial Counselor may also have a role in insurance verification and cost of care determination during this phase. The DCT Financial Counselor reviews the financial information related to the client's care and collaborates with DCT finance to ensure that all billing aspects are in place and accurate. This ensures that financial matters are addressed appropriately, and that the client's care can continue smoothly without any financial barriers.

By working together and fulfilling their respective roles effectively, these team members can ensure a smooth and coordinated admission process for clients, setting the stage for comprehensive and supportive care throughout the client's treatment journey.

As indicated, the DCT Financial Counselor (site dependent) and/or the DCT Social Worker or Discharge Planner should initiate any applications for Medical Assistance and provide it to the TCM for processing by the CFR.

Reviewing Conditions of Release

DCT CAS team confirms MN Status 611 status and communicates legal status to DCT Social Worker.

1. If no 611 is identified – standard discharge process is followed.

2. If 611 is identified – conditional release orders and bail conditions are reviewed.

- DCT and TCM partner to provide input on bail conditions and confirm path forward.
- DCT will facilitate the ROI process and determine if legal consultation with DCT and/or county legal resources is needed. Depending on the client's guardianship status, DCT ensures that the necessary releases of information are signed and provided to Health Information Management Services (HIMS) for the releasing of any medical records and subsequent disclosure tracking. In cases where clients are their own guardians but are unwilling to sign, DCT staff shall review the Executive Release of Information Policy to determine if an alternative process can be initiated without delay. Sec. 611.46 MN Statutes
    a. The DCT General Councils Office and the appropriate county legal contact / public defender may provide collaborate and share advisement back with DCT and the TCM.

Assessment, Treatment and Discharge Planning

Effective discharge planning is a critical component of the treatment process and should begin at the time of admission. As discharge planning becomes active, the assessment process is initiated to determine the supports and services an individual will need to be successful post-discharge. Planning should not presume a facility-based placement; instead, it must prioritize integration into the most inclusive, least restrictive setting possible, consistent with the individual's preferences, strengths, goals, cultural considerations, and recovery-oriented, trauma-informed practices.

The assessment and funding determination processes guide service eligibility, level of care, and authorization decisions and ensure alignment across treatment, case management, and long-term support systems. Disability-based waivers are a resource of last resort and are not the only pathway to a successful discharge; alternative funding and service options must be considered whenever appropriate.

Identifying Services and Level of Care

The Targeted Case Manager (TCM) and DCT Social Worker/Discharge Planner work collaboratively to determine the appropriate level of care and identify services—residential when necessary—to support a successful transition to the community. Planning must not assume a facility-based placement; rather, it must prioritize integration into the most inclusive, least restrictive setting possible, consistent with the individual's preferences, strengths, goals, cultural considerations, and recovery-oriented, trauma-informed practices. Disability-based waivers are a resource of last resort and are not the only option for discharge.

While the lead agency (typically the county) retains final responsibility for service authorization and waiver activation, the TCM and DCT Social Worker are critical in articulating:

- The individual's current functioning and support needs
- The recommended level of care
- Behavioral, medical, and psychosocial factors necessary to support stability and safety in the community
- Known risks or triggers and effective support strategies demonstrated during DCT care

Together, they contribute to a holistic, person-centered discharge plan that secures needed services (e.g., Community Residential Services, Psychiatric Rehabilitation Treatment Facility, housing with support, staffing,

mental health care, transportation, day programming) while proactively mitigating risks and barriers to community living. All recommended services and supports must align with:

- The individual's choices and expressed goals
- Identified risks and assessed needs
- Federal and state requirements and the authorized service plan

This collaborative approach enhances continuity of care, promotes long-term success, and reflects DCT's commitment to individualized, recovery-focused planning in partnership with counties, providers, and the individuals served.

Communication, Service Coordination and LTSS Consultation

The DCT Social Worker/Discharge Planner and the TCM share responsibility for identifying, referring, and securing appropriate services and placements. The LTSS Assessor does not make referrals.

Together, DCT and TCM:

- Develop a list of potential discharge placements aligned with the determined level of care.
- Identify anticipated barriers to discharge, including licensing, rate exceptions, benefit or service eligibility issues, or the need for additional DHS supports.
- Initiate consultations with the Transitions to Community / Whatever It Takes / Complex Transitions Team when additional coordination or system-level support is needed.

For hospitals and short-term residential settings, active discharge planning begins at the time of discharge. While active discharge planning may occur later for individuals served within Forensic Services and other long-term DCT sites, during the active discharge planning phase, team members are expected to communicate at least weekly to review assessment status, funding determinations, referral progress, and barriers to discharge. Consistent communication is essential to ensure timely, coordinated, and person-centered transitions from facility-based care to the community.

Successful transitions from DCT facilities to community settings require more than a one-time engagement with the CFR's Long-Term Services and Supports (LTSS) teams. To ensure the viability and sustainability of the discharge plan, ongoing consultation with LTSS should occur throughout the planning process—not just at the point of waiver opening or discharge readiness. Early and sustained collaboration ensures that discharge planning efforts remain realistic, actionable, and aligned with waiver policy and infrastructure. It also allows the interdisciplinary team, including DCT social workers, TCMs, providers, and guardians, to make informed decisions and adjust courses if service proposals are not viable or timely.

Keys Roles and Responsibilities for Successful Discharge Planning

DCT Social Worker or Discharge Planner

The DCT Social Worker or Discharge Planner leads discharge planning coordination and ensures the foundational processes are in place to support assessment, funding determination, and placement planning.

Key responsibilities include:

- Obtaining appropriate releases of information (ROI) and ensuring disclosures are tracked through HIMS. In cases where clients are their own guardians but are unwilling to sign, DCT staff shall review the Executive Release of Information Policy to determine if an alternative process can be initiated without delay.
- Establishing early and ongoing communication with the county Targeted Case Manager (TCM) and Long-Term Services and Supports (LTSS) teams, including the assumed host county and the County of Financial Responsibility (CFR).
- Participating with the TCM in treatment team and other relevant patient-centered meetings to maintain unified discharge planning.
- Assessing and documenting discharge needs, referral made and their status, support requirements, and anticipated barriers.
- As detailed below, in partnership with TCM, making referrals for placements and services to meet after-care needs.
- When waiver-funded services are determined to be the appropriate funding pathway, initiating a MnCHOICES referral to the host county and connecting with the CFR LTSS team. For clients under commitment with Dakota, Hennepin, and Ramsey Counties, please follow the below guidance:
    - **Dakota:**
        - MnCHOICES Assessment requests will be sent to the host county where the facility is located.
        - **For Adult Clients:** Mary Hennen – Mary.hennen@co.dakota.mn.us
        - **For Child/Adolescent Clients:** Notify Nikki Conway nikki.conway@co.dakota.mn.us to help guide this process.
    - **Hennepin:**
        - For individuals Anoka Metro Regional Treatment Center or Forensic Services, the assessment is directly completed by Hennepin County. In cases where the individual is site in Greater Minnesota, programs such as CBHH (Community Behavioral Health Hospital), CABHH (Child and Adolescent Behavioral Health Hospital), CARE (Community Addiction Recovery Enterprise), and MSHS (Minnesota Specialty Health System), referrals should be sent to the host county for the MnCHOICES assessment to be completed.
        - **For Adult Clients:** Advise LTSS by emailing hsph.ltss.ia.bhi.supervisors@hennepin.us at the time or prior to a host county/county of location MnCHOICES referral to confirm CFR and start planning.
        - **For Child/Adolescent Clients:** Notify Dawn Barfnecht at Dawn.Barfnecht@hennepin.us at the time or prior to a host county/county of location MnCHOICES referral to confirm CFR and start planning.
    - **Ramsey:**

        - For individuals Anoka Metro Regional Treatment Center or Forensic Services, the assessment is directly completed by Ramsey County. TCM who need MnCHOICES Assessments prioritized to ensure a timely discharge should send those requests to Misty Williams: RCMNChoices.Intake@co.ramsey.mn.us. In cases where the individual is site in Greater Minnesota, programs such as CBHH (Community Behavioral Health Hospital), CABHH (Child and Adolescent Behavioral Health Hospital), CARE (Community Addiction Recovery Enterprise), and MSHS (Minnesota Specialty Health System), referrals should be sent to the host county for the MnCHOICES assessment to be completed. TCM are encouraged to request that the MnCHOICES assessment be prioritized to ensure a timely discharge.

- Ensuring counties receive ongoing documentation throughout the episode of care, including intake assessments, medication administration records, progress notes related to incidents or highly symptomatic behavior, and psychological consultations or testing (e.g., IQ testing, risk assessments, neuropsychological evaluations).
    - **For Mental Health and Substance Abuse Treatment Services (MHSATS) sites (AMRTC, CABHH, CBHH, CARE, and MSHS):** records should be provided to the TCM throughout the episode of care through HIMS. For admissions exceeding one year, promptly providing updated assessments to TCM and the CFR LTSS worker (as appropriate).
    - **For Forensic Services:** Records may be requested by the county by sending a request to: dct.release.of.information.dhs@state.mn.us.

Targeted Case Manager (TCM)

In partnership with the treatment team, the TCM takes the lead in coordinating discharge placement needs as determined by the treatment team.

Key responsibilities include:

- Assessing the individual's need for placement following discharge and exploring all available funding pathways, recognizing that disability-based waivers are a last resort
- Determining whether waiver funding is required and initiating discussions with DCT and LTSS accordingly
- Notifying the CFR LTSS team of the potential need for waiver services
- Confirming roles and responsibilities with the CFR and DCT team
- Collaborating with the DCT Social Worker to identify and pursue appropriate discharge placement referral opportunities
- Maintaining active engagement with the DCT Social Worker upon case assignment and communicating at least weekly throughout hospitalization

When waiver funding is not required, a MnCHOICES referral is not initiated, waiver processes are bypassed, and discharge planning proceeds using alternative funding and service options.

Long-Term Services and Supports (LTSS) Worker

The LTSS worker provides education to the individual, care partners, and system partners regarding waiver processes, types of services, levels of care, authorization criteria, disability certification, and Medical Assistance (MA) requirements. LTSS does not have capacity to attend treatment team meetings; however, through consultation, CFR LTSS ensures the team's direction aligns with assessed need, eligibility requirements, and individual choice.

LTSS responsibilities may differentiate between the Host County and the County of Financial Responsibility (CFR) as outlined below.

Host County LTSS Responsibilities

The Host County LTSS is responsible for completing assessment-related activities when the individual is physically located within the host county, regardless of county of financial responsibility. These responsibilities include:

- The LTSS assessor coordinates the MA-Long-Term Care (LTC) application and AVS and shares with CFR LTSS.
- Initiates the appropriate waiver processing per assistance type.
- The host county LTSS assessor shares the outcome of the MnCHOICES assessment with the client, DCT and CFR partners.
- Coordinating with economic assistance to initiate a State Medical Review Team (SMRT) review when an individual is not certified disabled.
- Collaborating with HIMS to obtain and submit required clinical documentation to support the MnCHOICES and SMRT processes.

County of Financial Responsibility (CFR) LTSS Responsibilities

The CFR LTSS retains responsibility for eligibility determination, service planning, and service authorization, regardless of the location of the commitment court or which county completed the assessment. Core CFR responsibilities include:

- The CFR LTSS receives MA-LTC and AVS and shares information with county eligibility for waiver processing. In Ramsey County, MA-LTC applications will be submitted to the RC Utilization FAS worker for processing.
- Collaborating with the CFR Eligibility Worker to complete and submit SMRT paperwork when required.
- Determining eligibility for waiver and non-waiver services based on assessed need and statutory criteria.
- Providing ongoing communication regarding eligibility, authorization status, and service planning decisions to the DCT Social Worker, TCM, and other care partners.
- Ensuring all service planning and authorization decisions reflect assessed need, eligibility requirements, and individual choice.

DCT Financial Counselor

The DCT Financial Counselor supports benefit coordination and eligibility processes by:

- Contacting the Senior Linkage Line to verify Medicare Part D enrollment and eligibility for the Low-Income Subsidy (Extra Help).
- Obtaining ROIs, as needed, to verify coverage and initiate Part D enrollment when applicable.
- Completing DHS-IMD status submissions (as applicable)
- Reviewing eligibility and cost-of-care determinations following status submission.

MnCHOICES Financial and Functional Eligibility Determination & Service Reconciliation

Once a potential placement has been identified and the MnCHOICES assessment is completed, the CFR LTSS team leads the interactive service reconciliation and rate-setting process with the prospective provider. This process is required for community residential services, customized living, integrated community supports, and other waiver-funded residential services. Key processes during this phase include:

- **Assuring Provider Readiness:** The team ensures that the service provider is willing and able to provide services to the individual. They verify that the services are person-centered, reflect client choice and preference to the extent possible, and that the provider has independently evaluated the service needs and sent a service proposal to the assessing LTSS worker.
- **Supporting Providers in the Rate Process:** To ensure timely and successful discharges, it is essential that both DCT, the TCM and CFR LTSS actively assist the receiving community provider in navigating the service authorization and rate management processes. DCT and TCM should encourage providers to respond to and communicate with the LTSS team. Admission to waiver funded residential services is a two-step approval. The provider must indicate they can serve a person, and the assessor must indicate that services are agreed upon and admission can occur. Community providers may indicate they can admit a person prior to service authorization. However, services and payment cannot be authorized until the reconciliation process is completed, per DHS and CMS policy and State statute. Admission cannot occur prior to communication from LTSS that the process is complete and authorized.
- **Service Reconciliation and Rate Calculation:** The LTSS Assessor or Waiver Case Manager completes the service reconciliation process based on the assessed needs. Once there is agreement on services, the information is entered into the Rate Management System (RMS) to calculate the rate. The community provider confirms in writing they can provide the agreed upon services at the RMS rate. Rates are informed by the MnCHOICES assessment and determined by the CFR LTSS for individuals on disability waivers. For individuals aged 65+ who have never been on a disability waiver, the Elderly Waiver applies; the host county LTSS completes the required tools and forwards them to the county of residence or managed care plan. For disability waivers, the CFR LTSS conducts interactive service reconciliation and rate settings with the provider. This process may occur earlier and continue throughout planning for optimal outcomes. DCT and the TCM support providers and LTSS throughout the rate-setting process to promote timely completion.
- **Waiver Processing and Medical Assistance Authorization:** The county financial worker completes waiver processing and authorizes Medical Assistance, communicating the determination back to the CFR LTSS team. The county financial worker consults with the DCT Financial Worker as needed. While the waiver cannot be opened prior to discharge, CFR LTSS must confirm to the TCM and DCT that waiver services are authorized prior to setting discharge dates.

- **Opening the Waiver**: LTSS must indicate that waiver services can open and admission to waiver funded residential services is authorized prior to discharge.

The TCM and DCT Social Worker/Discharge Planner play a supportive role in the service reconciliation and rate-setting process, assisting the LTSS worker in ensuring effective communication with the service provider and all involved parties. Collaboration and clear communication between team members and the service provider are essential to ensure a smooth transition and successful implementation of the service plan.

Once the service reconciliation process is completed and the waiver is ready to open and LTSS has indicated services can start, it becomes the responsibility of the DCT team to work with all parties, including the placement provider, to establish a discharge date and communicate this effectively. DCT needs to communicate discharge occurred on the planned date. This collaborative approach ensures that all aspects of the transition are coordinated and aligned to support the individual's successful discharge and integration into the new placement.

This structure ensures assessments are completed efficiently by the Host County while maintaining clear statutory accountability with the County of Financial Responsibility for eligibility determination, service planning, and authorization. As noted above, in some circumstances for Hennepin and Ramsey County Clients, the CFR LTSS team assumes responsibilities for all steps.

Provider Responsiveness and Contingency Planning

To advance a discharge plan, selected community service providers must have the proper licensing credentials and capacity to provide services specific to size, location and age limitations. Service providers need to be responsive and follow through on the steps identified by the LTSS team. These steps may include submitting necessary documentation (e.g., provider service proposals or 6790s, NPI or other licensing verifications, etc.), participating in discharge planning meetings, and demonstrating readiness to meet the individual's identified service and support needs.

If a provider fails to complete these steps within a reasonable timeframe—or is otherwise unresponsive—it can significantly delay the individual's transition and create downstream barriers for all parties involved. Therefore, DCT, county case managers, and LTSS teams must clearly communicate expectations, set realistic deadlines, and document provider engagement. If engagement with a selected provider is not productive or moving forward, consideration of that provider should end to allow the process to start with a different provider.

To mitigate risk and avoid discharge delays, teams should also:

- Avoid placing all focus on a single provider option without assessing its feasibility
- Actively develop contingency plans by identifying alternate providers or service models that could be pursued if the primary plan becomes unworkable
- Maintain open communication with LTSS to explore backup plans that are consistent with the individual's needs and waiver eligibility
- Involve the individual (and their guardian, if applicable) in understanding these scenarios and helping to prioritize alternatives

This approach ensures the team remains flexible and proactive, especially in cases where provider capacity is limited or when the individual's needs require highly specialized services. Planning for contingencies is not only prudent—it is essential to maintaining momentum in the discharge process and upholding the individual's right to timely transition to the most integrated setting appropriate.

Discharge and Structured Handoff

Once service reconciliation is complete and LTSS confirms services may begin, the DCT team coordinates with all parties, including the provider—to establish and communicate a discharge date.

Key steps include:

1. DCT completes a final review for legal consultation needs; the DCT Competency Attainment team coordinates with the court as required.
2. HIMS files the required 5-day discharge notice in the EMR and with the court.
3. Legal proceedings occur to address custody determinations:
    - If Notice of Discharge is not approved, the individual may return to custody if indicated.
    - If approved, discharge proceeds as planned.

Hand-off Communication

To support continuity of care, DCT initiates a structured handoff process with the TCM, LTSS partners, and the receiving provider. This includes timely communication regarding discharge timing, final service authorizations, and critical support needs.

Ensuring the provider has this context supports a safer and more successful transition and promotes long-term stability in the community setting. The handoff must include meaningful, person-centered information, such as:

- What is important to and for the individual
- Strengths, preferences, motivators, and triggers
- Required support strategies
- Ongoing medical, behavioral, and cultural considerations

At discharge:

1. DCT communicates the confirmed discharge date and coordinates transportation.
2. CFR LTSS opens authorized waivers upon receipt of discharge confirmation (if applicable).
3. The DCT Financial Worker updates the patient status code (removing the U code).
4. HIMS sends the TCM the transitional care record, including the My Aftercare Plan, discharge summary, and required supporting documents.
5. The county TCM assumes lead responsibility for community integration and ongoing monitoring.

This end-to-end process ensures regulatory compliance, minimizes delays, and supports timely, safe, and person-centered transitions from DCT facilities to community-based services.

Frequently Asked Questions

What if the providers are non-responsive?

To advance a discharge plan, selected community service providers must have the proper licensing credentials and capacity to provide services specific to size, location and age limitations. Service providers need to be responsive and follow through on the steps identified by the LTSS team. These steps may include submitting necessary documentation (e.g., provider service proposals or 6790s, NPI or other licensing verifications, etc.), participating in discharge planning meetings, and demonstrating readiness to meet the individual's identified service and support needs.

If the provider is not accountable to completing the steps above, and after a follow-up call and/or email remains unresponsive, move on to the next suitable alternative.

Why is clear and ongoing communication so critical?

Clear and consistent communication is crucial in the process of planning for discharge and coordinating care among healthcare facilities, TCMs, and LTSS and Economic Assistance departments. Here are some reasons why:

1. **Ensures all parties are on the same page:** Clear communication helps to ensure that all stakeholders involved in the care of the client are aware of the client's needs, preferences, and goals. This alignment can help prevent misunderstandings or conflicts that may arise due to differing interpretations of information.

2. **Promotes collaboration:** Effective communication fosters collaboration among healthcare professionals, TCMs, and LTSS and Economic Assistance departments. By sharing information and working together, these parties can develop a comprehensive discharge plan that addresses all aspects of the client's care and support needs.

3. **Facilitates timely decision-making:** Clear communication helps to streamline the decision-making process and allows for quick and efficient resolution of any issues or challenges that may arise during the discharge planning process. This can help to prevent delays in the transition of care and ensure that the client receives the necessary support in a timely manner.

4. **Enhances continuity of care:** Consistent communication ensures that all parties involved in the care of the client are informed about the client's progress, changes in condition, and any updates to the discharge plan. This helps to promote continuity of care and ensures that the client's needs are met throughout the transition to the next level of care.

Why is it vital to clearly articulate the level of care required to support the client?

It is important for all parties involved in the care of the client to clearly articulate the level of care needed to support the client for several reasons:

1. **Accurate assessment:** Clear articulation of the level of care needed helps in accurately assessing the client's needs. This information is crucial for determining the appropriate level of support and services required to meet the client's health and well-being needs.

2. **Effective care planning:** When all parties clearly communicate the level of care needed, it helps in developing an effective care plan that addresses the client's specific needs. This ensures that the client receives the necessary support and services to promote their overall health and well-being.

3. **Collaboration among stakeholders:** Clear communication about the level of care needed fosters collaboration among healthcare facilities, TCMs, and LTSS and Economic Assistance departments. This collaboration is essential for developing a comprehensive plan that meets the client's needs and ensures a smooth transition to the most integrated care setting.

4. **MnCHOICES Assessment:** Documentation that clearly reflects the level of support and services needed by the client can be used as collateral information in the MnCHOICES Assessment process. This assessment evaluates the client's needs and determines eligibility for long-term support services, so accurate and detailed information is essential for a thorough assessment.

The clear articulation of the level of care needed by the client is essential for accurate assessment, effective care planning, collaboration among stakeholders, and facilitating the MnCHOICES Assessment process. It ensures that the client receives the appropriate level of support and services to promote their health and well-being.

Why is important that DCT provides ample notice of treatment team meetings to county and keeps to the schedule?

It is important for the facility to provide ample advance notice of treatment team meetings to the TCM for several reasons:

1. **Collaboration and coordination of care**: Treatment team meetings often involve discussions about the client's care plan, progress, and any changes in treatment. By inviting the TCM to attend these meetings, the facility can ensure that all stakeholders are on the same page and can collaborate effectively to provide the best possible care for the client.

2. **Input from the TCM:** The TCM plays a crucial role in advocating for the client's needs and coordinating services. By attending treatment team meetings, the TCM can provide valuable input, share important information, and address any concerns or questions related to the client's care.

3. **Timely decision-making**: Providing advance notice of treatment team meetings allows the TCM to plan their schedule accordingly and plan to attend the meeting. This ensures that decisions can be made in a timely manner and that any issues or concerns can be addressed promptly.

4. **Maximizing the effectiveness of the meeting:** Having the TCM present at the treatment team meeting can help ensure that all relevant information is shared and discussed. This can lead to more productive and efficient meetings, as all parties involved in the client's care are able to contribute their perspectives and expertise.

Why is it essential that TCMs attend treatment team?

It is important for the TCM to be present at treatment team meetings, either in person or virtually, for several reasons:

1. **Collaboration and coordination of care:** The TCM plays a key role in advocating for the client's needs and coordinating services. By attending treatment team meetings, the TCM can ensure that they are informed about the client's care plan, progress, and any changes in treatment. This collaboration is essential for providing comprehensive and coordinated care for the client.

2. **Input and advocacy:** The TCM can provide valuable input, share important information, and address any concerns or questions related to the client's care during the treatment team meeting. Their presence allows them to advocate for the client's needs and ensure that the client receives the appropriate level of support and services.

3. **Timely decision-making:** Having the TCM present at the treatment team meeting enables timely decision-making and ensures that any issues or concerns can be addressed promptly. This can help to prevent delays in the client's care and support their overall well-being.

4. **Engagement and visibility:** Attending treatment team meetings, either in person or virtually, allows the TCM to actively engage in discussions, interact with other team members, and see the client. This level of engagement and visibility can help the TCM better understand the client's needs and advocate for them effectively.

DCT should make every effort to engage TCM in treatment team meetings. This includes making every effort to conduct meetings via video presence when they are unable to attend in person before moving to defaulting to the telephone.

What is the SMRT Process?

The State Medical Review Team (SMRT) determination process is a crucial step for individuals seeking access to certain services and support for people with disabilities. Here is an overview of the process:

1. **Initial Medical Assistance Application:** Applicants would submit an initial Medical Assistance application to their county, indicating that they have a disability. This application is the first step in determining eligibility for Medical Assistance programs and services. The DCT Financial Counselor may help the DCT Social Worker or discharge planners with this process.

2. **Processing by the County:** The County Economic Assistance processes all applications and determines benefit eligibility. LTSS and TCM may be able to support the information getting to Economic Assistance, but do not control or have responsibility for the process.

3. **Completion of the "Referral for Disability Determination" Form:** As part of the determination process, the county financial unit would complete a "Referral for Disability Determination" form. This form provides detailed information about the applicant's disability status and medical condition, along with any supporting documentation or medical records that may be required for disability determination. The LTSS Assessor works with TCM and DCT to initiate the SMRT and Assessment. Please note: the SMRT team will not review referrals unless a MnCHOICES Assessment is initiated. An expedited SMRT can be requested if a placement has been identified and a MnCHOICES assessment has been completed.

4. **Submission to the State Medical Review Team:** Once the "Referral for Disability Determination" form is completed, the county financial unit will submit it to the SMRT for further evaluation. At the time of submission, a MnCHOICES referral date should be provided to the SMRT team to expedite the process. The SMRT is responsible for reviewing the information provided, conducting additional assessments if necessary, and deciding regarding the applicant's disability status. All applications should be marked as expedited.

5. The SMRT Team will mail a request to the person for additional information. This will include the DHS-6124 Release of Information and, generally, the DHS-6125 Adult Disability Worksheet. As a person may not have immediate access to their mail, coordination is required to ensure the documents are completed and submitted to SMRT. This step can only occur after SMRT has opened a case. Return of these documents to SMRT needs to be coordinated and confirmed with the DCT Financial Counselor, TCM, and Assessor.

6. **Support Documentation Is Submitted Through a Secure Portal:** For individuals in a Direct Care and Treatment Facility, the Health Information Management Services team will submit the requested documents to SMRT as authorized by the release of information.

7. **Disability Determination:** The SMRT will assess the applicant's medical records, conduct any necessary medical evaluations, and decide regarding the applicant's disability status. This determination is crucial for accessing certain services and support that are available to individuals with disabilities.

By following the steps outlined above and providing accurate and complete information, applicants can ensure that their disability determination process proceeds smoothly and efficiently, ultimately leading to access to the necessary services and support for their needs.

Where do I send Medical Assistance applications?

Following a MnCHOICES Referral, MA applications needed are completed by either DCT or County workers. The MnCHOICES assessor will complete additional, supplemental, financial documentation needed to open a person to waiver. Send completed applications to the county of financial responsibility's financial department.

Forms can be found here:

- Printable application forms for health care programs / Minnesota Department of Human Services
- County and Tribal Nation Agency Address and Phone Number [DHS-5207]

It may be beneficial to have a brief discussion about the MA applications about settings with or without a Financial Counselor.

Hennepin:

If a Hennepin Assessor is assigned, the applications can be sent to the Assessor, and the Assessor can upload or fax them:

- The application can be faxed to 612.288.2981
- InfoKeep Sign in or create an InfoKeep account | InfoKeep

Ramsey:

Prior to a MnCHOICES Referral:

- **If MA-DX is needed and not in place, submit the following via fax to Adult Facility and Waiver (AFAW) Unit at 651-266-3932:**
    - Applications for Medical Assistance for Long-Term Care Services (DHS-3531)
- Lead Agency Assessor/Case Manager/Worker Communication Form (DHS-5181)

- Authorization to Obtain Financial Information from the Asset Verification Service (DHS-7823)

- **If MA-DX is in place, but a waiver is not yet open, submit to CSS Resource Team: fas.cssrequestwaiver@co.ramsey.mn.us.**

MA applications are completed ahead or simultaneously along with a MnCHOICES Referral, and required for the MnCHOICES assessor at the time of the assessment.

Requests can be made to the Middle Ground Supervisor to prioritize MA Applications to facilitate a timely discharge**.**

How long are MnCHOICES Assessments valid?

Effective July 1, 2025, MnCHOICES assessments are valid for 365 days. However, an Initial Assessment Review is required once an assessment becomes older than 60 days. An IAR will need to be completed between day 60 and 365 to open to waivers. It is possible that the MA-LTC financial documents will need to be resubmitted as well. An IAR typically involves a review of records to ensure there are no changes to assessed needs and a phone conversation with the individual needing services.

I am getting stuck! What do I do?

When you encounter barriers in your work, know that you are not alone. Challenges are a normal part of this complex system, and there is a structure in place to help you navigate them. Our team is committed to working through issues collaboratively and ensuring you feel supported every step of the way.

To help resolve concerns effectively, we encourage you to follow the escalation path outlined below:

1. **First-Line Supervisor**: Start by connecting with your immediate supervisor, who serves as your primary resource for addressing challenges. In many cases, they can help resolve concerns efficiently at the operational level. Your supervisor may either assist you in resolving the issue directly or collaborate with their counterpart at the partnering agency before escalating the matter through the chain of command.

2. **Second-Line Supervisor**: If your concern remains unresolved or needs additional input, your second-line supervisor can assist in addressing more complex or systemic issues.

3. **Divisional Manager or Director**: For persistent challenges or those that cross teams or systems, escalation to divisional leadership can help identify broader solutions, remove structural barriers, and provide strategic direction.

4. **Executive Leadership**: When appropriate, issues may be brought to executive leaders to access higher-level decision-making or agency-wide resources to support resolution.

Throughout this process, collaboration is key. State and county peers, guardians, and other external partners may be engaged as appropriate to ensure continuity, alignment, and creative problem-solving. Many issues can't be solved in isolation—engaging others early and transparently can help us get to better outcomes, faster.

Please don't wait until a challenge feels unmanageable. The sooner you reach out, the more options we may have. While some questions will take time to answer, we are committed to following up, keeping you informed, and sharing what we know as soon as we can. Your voice matters—let's work together to find solutions.

I work for a contracted agency and need help from the county. What do I do?

Reach out the MnCHOICES interagency point of contact for the client CFR: MnCHOICES Interagency Contact Point (MICP) List

Hennepin:

- For behavioral targeted case management questions, contact: Neerja.Singh@hennepin.us.
- If it is contracted Waiver Case Management, requests for support should be sent by the Contracted Case Manager to: hsph.ltss.ccmc@hennepin.us
- If it is a LTSS MnCHOICES Assessment County process, questions should go to the assigned Hennepin Assessor. If no Assessor is assigned, questions can be emailed to: hsph.ltss.ia.bhi.supervisors@hennepin.us

Ramsey:

- Each of the contracted agencies in Ramsey County is assigned one of the supervisors below to serve in a liaison/consulting capacity:
    - General Inquiry — RCMNChoices.Intake@co.ramsey.mn.us
    - Janice Williams-Graff (Adult) — janice.williams-graff@co.ramsey.mn.us
    - Charles Goff (Adult) — charles.goff@co.ramsey.mn.us
    - Kyle Davis (Adult) — kyle.davis@ramseycountymn.gov
    - Misty Williams (Youth/Families) — misty.williams@co.ramsey.mn.us

My client is experiencing some setbacks in the community after discharge. What do I do?

Setbacks are a common and normal part of the recovery process for individuals receiving care and support for mental health or substance use issues. It is important to recognize that setbacks can happen for various reasons and do not indicate a lack of progress or effort on the part of the client. Instead of taking a punitive approach,

such as revoking clients provisional discharge from commitment, our goal is to increase support to help clients navigate through these setbacks and continue their journey towards recovery.

Recovery is not a linear process, and it often involves ups and downs, challenges, and obstacles along the way. Setbacks can be triggered by various factors, such as stress, life events, triggers, or underlying issues that may resurface during the recovery journey. It is essential to approach setbacks with empathy, understanding, and a focus on providing additional support to the client during these challenging times.

Increasing support for clients experiencing setbacks can involve various strategies, such as:

1. Providing additional counseling or therapy sessions to help clients process their feelings, thoughts, and experiences related to the setback.
2. Offering peer support or group therapy sessions where clients can connect with others who may have had similar experiences and can offer empathy, validation, and encouragement.
3. Collaborating with the client to reassess their treatment plan and goals and making necessary adjustments to better support their needs.
4. Encouraging self-care practices, coping strategies, and relaxation techniques to help clients manage stress and build resilience.
5. Involving family members, caregivers, or other support systems in the client's care to provide additional support and encouragement during setbacks.

By taking a supportive and understanding approach to setbacks in the recovery process, we can create a safe and nurturing environment for clients to navigate through challenges and continue their journey towards wellness and stability. Our focus is on empowering clients, building resilience, and fostering a sense of hope and optimism as they work towards their recovery goals.

I have run out of ideas. Who can help me?

In the event of a setback in the recovery process that may lead to the potential revocation of the provisional discharge of civil commitment, use your team and clinical supervision for support, suggestions and guidance. Additionally, it is important for the state to support the county in exploring alternative options to prevent such an outcome. Here are some ways in which the state can collaborate with the county to provide necessary support and resources for individuals in need:

1. **Engage with the DCT Transitions Team:** The state can reach out to the DCT Transitions Team to explore available options. This team is familiar with all DCT programs and it is connect at network of hundreds of social workers across the state. As such, they may be able to provide guidance and assistance in identifying appropriate services and resources to address the individual's needs.

2. **Utilize Southern Cities Clinic for Support:** The Southern Cities Clinic may be able to offer specialized support for individuals who need psychiatric care and treatment. Collaborating with this clinic can provide additional resources and expertise to help the individual navigate through their setback and continue their recovery journey.

3. **Community Support Services Team:** For individuals with civil commitment as a person with a developmental disability, mental illness, or chemical dependency, the DCT may have options through the Community Support Services Team. This team can provide tailored support and services to address the individual's specific needs and facilitate their recovery process.

4. **Community Integrated Services Team:** Individuals who were committed as mentally ill and dangerous may benefit from reengaging with the Community Integrated Services Team. This team can offer support and resources to help the individual reintegrate into the community and access the necessary services and support for their well-being.

5. **Collaborate with Additional Resources:** In some cases, involving more people in the support network can help identify additional resources and interventions that may prevent the need for a more restrictive intervention. By working together and leveraging a diverse range of resources, the state and county can provide comprehensive support to individuals experiencing setbacks.

The DCT Transitions Team can help you triage and navigate any of these services: dct.transitions@state.mn.us.

By proactively exploring these options and collaborating with relevant teams and resources, the state can support the county in preventing the revocation of the provisional discharge of civil commitment and ensuring that individuals receive the necessary support to overcome setbacks and continue their journey towards recovery and wellness.

What is the DHS Complex Transitions Team and Transitions to Community Initiative and how can they help?

The Transition to Community Initiative (TTC) program has been successful in addressing discharge barriers and assisting people to achieve community tenure. TTC can provide grants to counties to utilize strategies that have no other funding sources to reduce barriers that keep people from moving to the least restrictive setting. The TTC program can also address a person's unique needs through the "Whatever it Takes (WIT)" services that enhance creative solutions that meets the needs of the person.

The Complex Transitions Team (CT) was established in 2023 to help with the continual need from hospital decompression. CT Team prioritize access to resources to support people that are experiencing an overstay in an institution or hospital. For more information and FAQs, see the Complex Transitions Team webpage.

I have suggestions that could make this process or training materials even better. Who should I connect with?

This Standard Operating Procedure (SOP) and the associated tools are being released for pilot use across Direct Care and Treatment (DCT) with our county partners. The intent of this pilot phase is to support real-world applications, identify operational gaps, and ensure the guidance reflects how work is performed across systems.

Frontline staff feedback is a critical component of this process. Input from DCT staff, Targeted Case Managers, Long-Term Services and Supports teams, and community partners will be used to inform iterative updates. This SOP is expected to evolve over time as practice, policy, and system capacity change.

All participants are encouraged to share observations, suggestions, and identified barriers. Feedback that would enhance the clarity, accuracy, or usability of this document should be sent to:

- partner.experience.dct@state.mn.us

Ongoing feedback and continuous refinement are essential to ensuring this SOP remains a practical, effective, and trusted resource for supporting timely, coordinated, and person-centered discharges.

Glossary of Acronyms

Acronym	Full Term
AFAW	Adult Facility and Waiver
AMRTC	Anoka Metro Regional Treatment Center
AVS	Asset Verification Service
BH	Behavioral Health
CABHH	Child and Adolescent Behavioral Health Hospital
CAF	Combined Application Form
CARE	Community Addition Recovery Enterprise
CBHH	Community Behavioral Health Hospital
CBSM	Community-Based Services Manual
CFR	County of Financial Responsibility
COR	County of Residence
CRS	Community Residential Setting
CSS	Community Support Services
CT	Complex Transitions Team
DCT	Direct Care and Treatment
DHS	Department of Human Services
GA	General Assistance
FAQ	Frequently Asked Questions
HIMS	Health Information Management Services (DCT Medical Records)
ICS	Integrated Community Supports
ICSP	Integrated Community Supports Plan
IMD	Institution for Mental Disease
IQ	Intelligence Quotient
IMD	Institution of Mental Disease
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MA	Medical Assistance
MICP	MnCHOICES Interagency Contact Point
MHSATS	Mental Health and Substance Abuse Treatment Services
MSHS	Minnesota Specialty Health System
NPI	National Provider Identifier
PRTF	Psychiatric Rehabilitation Treatment Facility
RMS	Resource Management Specialist
ROI	Release of Information
SMRT	State Medical Review Team
SOP	Standard Operating Procedure
SSI	Social Security Income
TCM	Targeted Case Management
TTC	Transitional To Community Initiative
WIT	Whatever it Takes

Key Terms and Definitions

Waiver Funded Placement	A waiver-funded placement refers to a living arrangement and support services paid for by Medicaid through Home and Community-Based Services (HCBS) waivers. These placements allow individuals often those with disabilities, mental health needs, or age-related challenges to transition from institutional care (like hospitals or treatment facilities) into community-based settings such as CRS or Customized Living. The goal is to promote stability, independence, and integration into the community while ensuring the person's health and safety needs are met. Requires the MnCHOICES assessment.
Long term placement	A stable, ongoing living arrangement for individuals discharged from psychiatric or residential care who need continuous support with daily living. These placements offer sustained assistance rather than short-term or clinical treatment.
Short term placement	A time-limited, treatment-focused setting that a person may transition to after an acute psychiatric hospitalization when they require additional stabilization, structured programming or transitional support before returning to independent living or longer-term services. These placements have defined lengths of stay and clear clinical or functional criteria for discharge.
Placement	Not an acute psychiatric hospitalization, a clinical intervention, or a treatment episode. It is not a continuation of inpatient care, nor is it itself a medical or psychiatric service. Instead, a placement refers only to the setting or living arrangement a person transitions to after hospitalization or residential treatment.
Waiver Placement Types	Examples include, but are limited to: • Community Residential Setting (CRS) / Licensed Residential Program under Chapter 245A / 245D: A licensed residential home for adults with disabilities or mental illness under Minnesota statutes (e.g., Chapter 245A, 245D) providing care, supervision, and support in a community setting. • Customized Living (CL)/24-Hr Customized Living: A setting for 18+ adults who receive a bundled package of regularly scheduled health-related and supportive services. Special attention must be paid to these settings to ensure they meet DHS age, size and location requirements. Not all Customized Living settings meet criteria to serve someone on a disability waiver. • Integrated Community Setting (ICS): Services that provide support and training/habilitation in community living service categories to adults aged 18 and older who reside in a living unit of a provider-controlled ICS setting (e.g., apartment in a multi-family housing building). ICS can be delivered up to 24 hours per day in the person's living unit or in the community.
Non-waiver funded Placement	Examples include, but are limited to: A board and lodge, shelter, IRTS or crisis center
Funding Types	Examples include: • Medicaid Home & Community Based Services (HCBS) waiver funding: e.g., the Brain Injury (BI) Waiver, Community Access for Disability Inclusion (CADI) Waiver, Elderly Waiver (EW) cover CL services. • Housing Support (formerly "Group Residential Housing") program may pay room & board for low-income adults with disabilities • Private pay by resident/family when they do not qualify for waiver or Housing Support.

	• State funds (via Minnesota Legislature appropriation) through DHS for room/board payments. • Rental subsidies, capital funding or operating funding (via Minnesota Housing Finance Agency and other state/federal programs).
LTSS Planning	Confirmation with partners on planning pathways, completion of the MnCHOICES Assessment, application for financial assistance submitted to economic assistance, conversation between TCM and waiver department, rate negotiation takes place, State Medical Review Team (SMRT) referral is made as needed by economic department (up to 6-8 months if not expedited) Long-term services planning begins with confirming the appropriate pathways in collaboration with key partners. The MnCHOICES assessment is completed to determine eligibility and service needs. An application for financial assistance is submitted to the Economic Assistance department, initiating the process for funding support. Coordination between the Targeted Case Manager (TCM) and the Waiver Department ensures alignment on service planning. Rate negotiations are conducted to establish appropriate funding levels. If necessary, the Economic Assistance team refers the individual to the State Medical Review Team (SMRT), a process that may take approximately 6 to 8 months unless expedited.
Process Lead/Quarterback	Targeted Case Manager (TCM) is the lead, other partners are collaborators and supporters.
Host County	The County in which the facility is located that would be responsible for the MnCHOICES assessment.
Discharge planning	Begins at point of admission, to guide the course of treatment.
Active discharge	Begins at point that next level of placement care options has been identified, and referrals can be made for placement with an idea of desired discharge timeline in mind. Point of view is primary to discharge facility. Consultation with partners on planning pathways.

Appendix 1: DCT Assessments

Assessment types vary by program; however, the non-exhaustive list below summarizes DCT assessments and associated timelines to help anticipate when documentation may be available for request.

CARE Admission Assessments

Assessment Type	Timeframe
Comprehensive Assessment	5 days
Diagnostic Assessment	10 days

Forensic Services Admission Assessments:

Assessment Type	Timeframe	Notes
Annual Medical Exam	Annually after initial admission	Includes physical assessment, labs, and screenings.
Brief Diagnostic Assessment	Upon admission or within 30 days (varies by referral)	Used for MI/CD/DD patients and returnees; informs treatment plan.
Comprehensive History and Physical	Within 24 hours of admission (Mon–Fri, non-holiday)	If admission occurs on weekend/holiday, Intake Physical completed within 24 hrs.; comprehensive completed next business day.
Comprehensive Psychiatric Assessment	Within 7 days (adults), within 5 days (under 18)	Must be documented in Avatar. Replaces initial if done within 24 hours.
Educational Assessment	Within 30 days of referral and every 3 years there after	Upon referral
Functional Behavior Assessment (FBA)	Within 30 days of meeting EUMR threshold; or within 60 days of referral	Used to identify triggers and inform Positive Support or Treatment Plans.
Good Lives/Psychosexual/Sex Offender Evaluations	Good Lives: Due on 45th day after referral	Assigned upon team referral with patient consent.
Immunization Assessment	At admission	Updates documented in Avatar and MIIC. Counseling provided.
Initial Psychiatric Assessment	Within 24 hours of admission	Includes patient interview, record review, safety and diagnostic considerations. Can be replaced by comprehensive assessment if completed within 24 hours.
Initial Psychological Assessment (IPA)	Within 30 calendar days of admission (per 253B.03)	Required for committed, court-ordered, or voluntary patients. Includes risk, cognitive, and emotional functioning.
Intake Physical Assessment	Within 24 hours of admission (when	Followed by comprehensive on next business day.

	comprehensive not possible)	
Medical Clearance for Activity	At admission	Clearance documented in Avatar.
Neuropsychological Assessment	As referred	Follows standard psychological assessment process. Focus on neurocognitive functioning.
Nursing Admission Assessment	Within 8 hours of admission	Includes the patient's physical health, mental health, substance use history, and functional status. Key areas include vital signs, allergies, behavioral symptoms, pain, suicide risk, nutrition, medications, skin integrity, fall risk, traumatic brain injury (TBI), and choking risk. For Forensic Nursing Home residents, additional screenings for pressure ulcers and skin tears are completed. These assessments guide the initial nursing care plan and support the broader treatment planning process.
Occupational Therapy Assessment	Ongoing per referral; FMHP reviewed weekly, FNH reviewed daily	Focuses on specific functional areas. Based on findings, chart review, team input, and observation if patient is unavailable.
Positive Supports Assessment (PSA)	As clinically indicated	Assesses strengths and needs; informs interventions to improve quality of life.
Psychological Update	Within 30 days of PD revocation (if past 60-day stay)	Update report with new test results and recommendations.
SUD Assessment	Within 60 days of admission	Required if screening indicates substance use history or referred by treatment team.
SUD Screening (Chart Review)	Within 30 days of admission	Chart review to identify substance use indicators; if negative, no further action is required. Assigned on a rotational basis.
Social Work Assessment	Within 30 days of admission	
Therapeutic Recreation Assessment	Within 30 days of admission; annually at FNH	Assesses leisure interests, history, and functional strengths/limitations.

Hospital Level of Care:

Assessment Type	Timeframe	Notes
Psychiatric Assessment	Initiated within 24 hrs.; completed within 60 hrs.	Includes provisional diagnosis and treatment recommendations
Inpatient History & Physical	Within 24 hrs. of admission	Includes medical history, physical exam, infectious disease risks
Neurological Screening	Within 24 hrs. of admission	Comprehensive exam if any deficits identified

Nursing Initial Plan of Care	Within 16 hrs. of admission	Includes GAIN-SS at AMRTC
Nursing Assessment & Basic Skin Assessment	Within 16 hrs. of admission	Ongoing per Pressure Injury and Wound Care Guide
Vulnerability Risk Reduction Plan (VRRP)	Initiated within 16 hrs. of admission	Forms basis of initial treatment plan
Social Work Assessment	By 11:59 PM on 5th calendar day post-admission	Includes interview, data collection, collateral contacts
Recreational Therapy Assessment	By 11:59 PM on 7th calendar day post-admission (if ordered)	Based on medical order
Occupational Therapy Evaluation	By 11:59 PM on 7th calendar day post-admission (if ordered)	Based on medical order
GAIN-SS	Within 1 day (CBHH/CABHH) or 16 hrs. (AMRTC)	AMRTC: Part of nursing plan; CABHH/CBHH: determined by site process
Cognitive Impairment Screener	As indicated	If cognitive impairment suspected from initial assessments
Integrated SUD/MH Inventory	By Day 5 (CBHH/CABHH); per clinical team (AMRTC)	Triggered by positive GAIN-SS
Nutritional Assessment	As appropriate	Follows MHSATS Policy 420-4120
Falls Risk Assessment	As appropriate	Follows MHSATS Policy 215-4160
Confusion Assessment Method (CAM)	As appropriate (excludes CABHH)	Follows MHSATS Policy 215-4245
Annual Reassessment (if >1 year hospitalization)	Before admission anniversary date	Psychiatric, Medical, Nursing, Social Work, RT, OT

MSHS Admission Assessments:

Assessment Type	Timeframe	Notes
Diagnostic Assessment	Day of admission or as soon as possible	Must be current; can be updated if within 30 days
Residential Health Screen	Day of admission	Required per MHSATS Policy 135-4010
Nursing Assessment	Within 24 hours if clinically indicated	Performed when health conditions warrant
Pain Assessment	Within 24 hours or sooner if in distress	Per MHSATS Policy 215-4310
Self-Administered Medication Assessment	Initial: Day of admission; Ongoing: as needed	Per MHSATS Policy 320-4060
Initial Dual Diagnosis Screening: CAGE-AID	Day of admission	Required for screening substance use; can be reused if <30 days
Integrated Dual Diagnosis Assessment	Within 5 calendar days of admission	Required if CAGE-AID or history indicates need

Functional Assessment	Within 3 calendar days of admission	Can be reused if done within last 30 days
History and Physical	Day of admission or within 24 hours	May be carried forward if completed in last 30 days
Individual Abuse Prevention Plan	By Day 5 post-admission	Based on vulnerability/risk assessment findings
Interpretive Summary	Following completion of all assessments	Summarizes findings and informs treatment plan

Appendix 2: Hennepin County SMRT Process for Disability Determination and MA-Disability

Purpose

To outline the coordinated workflow between DCT/AMRTC and Hennepin County for initiating disability determinations and opening Medical Assistance – Disability through the SMRT process.

Process Flow

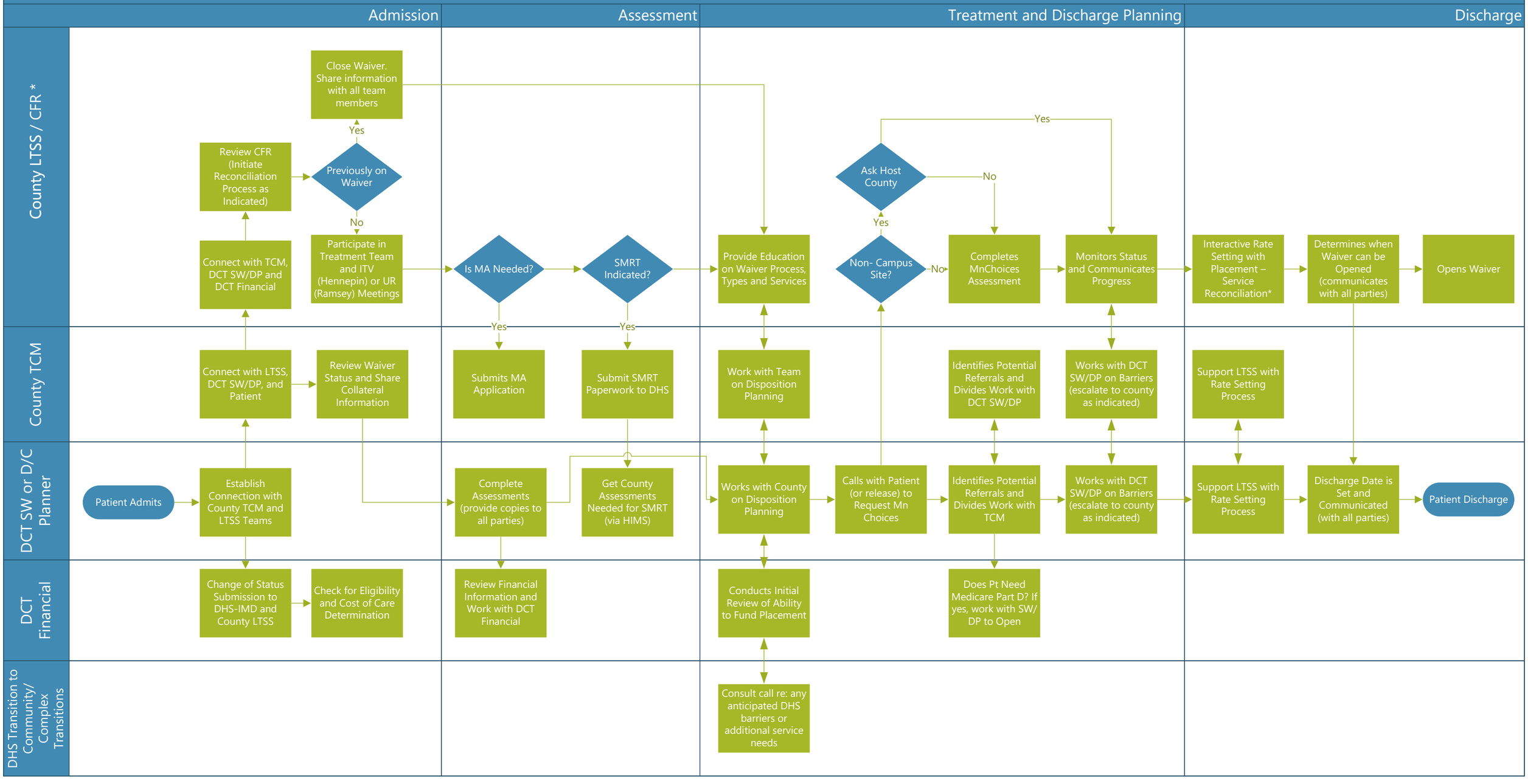
1. **Initial Identification**
    - **Responsible**: ITV Team (Interdisciplinary Treatment Team)
    - **Action**: Identify individuals who require a MnCHOICES assessment and discuss during ITV.
2. **MnCHOICES Referral Assignment**
    - **Responsible**: BHCM or AMRTC Social Worker
    - **Action**: Determine who will submit the MnCHOICES referral during the ITV discussion and submit the referral immediately.
3. **File Clearance Initiation**
    - **Responsible**: Tasha
    - **Action**:
        - Complete and send file clearance request to:
            - **Primary**: Heather Grotberg, Ron McClure
            - **CC**: Crystal, Mary, Cindy Solberg, AMRTC liaison
        - Include request for financial documents:
            - DHS-3531 or DHS-3543
            - AVS
        - *Use standard email template (found in "AMRTC File Clearance" tab).*
4. **Initiation of ES Case**
    - **Responsible**: Tasha
    - **Action**: Create DHS-5181 to open the ES (Eligibility Support) case and upload all supporting documents.
5. **Asset Verification**
    - **Responsible**: Ron
    - **Action**: Initiate AVS process.
6. **Launch SMRT**
    - **Responsible**: Ron
    - **Action**: Launch the SMRT request.
7. **Verify SMRT Launch**
    - **Responsible**: Ron
    - **Action**: Confirm in ECF (Electronic Case File) that HC ES has officially launched the SMRT referral.
8. **MnCHOICES Assessment**
    - **Responsible**: Mary
    - **Action**: Initiate MnCHOICES assessment to support the SMRT process.
9. **SMRT Referral Confirmation**
    - **Responsible**: Heather
    - **Action**: Confirm that DHS received the SMRT referral.
10. **SMRT Documentation**
    - **Responsible**: Heather

- **Action**:
    - Complete and upload the following to SMRT:
        - DHS-6124
        - DHS-6125
        - Medical records and other required documentation

11. **Notification of SMRT Decision**
    - **Responsible**: Tasha
    - **Action**: Monitor for ECF notification regarding SMRT decision and notify AMRTC team of the outcome.
12. **SMRT Expedited Request**
    - **Responsible**: Heather
    - **Trigger**: Once the individual is accepted and services identified
    - **Action**: Request expedited SMRT determination.
    - **Note**: Clarify notification pathway—does AMRTC Social Worker notify Heather?
13. **Final Eligibility Processing**
    - **Responsible**: Tasha and Ron
    - **Action**:
        - When residential service provider is identified:
            - If diagnosis processing is still pending, Ron finalizes case for disability (Dx) determination.

Appendix 3: SOP Flowchart

High-Level Flow Chart of LTSS Processes for Clients in DCT Facilities



* if any difference exists in County LTSS host and County CFR host, review the SOP narrative for specifics.

Draft April, 2026