Minnesota Senior Care (MSC+) and Minnesota Senior Health Options (MSHO)
Care Coordination (CC) Requirements for Institutionalized Members
Effective 1/1/2024

All Minnesota Senior Care Plus (MSC+) members and Minnesota Senior Health Options (MSHO) members are automatically assigned a Care Coordinator and receive care coordination until disenrollment. The assigned Care Coordinator (CC) must meet the definition of a Qualified Professional*. Care coordination services incorporate case management and consist of a comprehensive assessment of the member's condition, the determination of available benefits and resources, the development and implementation of an individualized Support Plan with performance goals, monitoring, and follow-up, as described in the grid below.

Ensure you are using the current version of any document. All related UCare forms can be found HERE; all DHS forms can be found HERE; and all DHS Bulletins can be found HERE.

Table of Contents

***If asterisk shown**, see Definitions/Acronyms section for a further explanation of that term.

Requirements Grid for Institutionalized Members	

Initial Assignment	Initial assignment* is the first day the care system or county receives the care coordination enrollment roster. **Upon receiving the monthly enrollment roster, the Care Coordinator (CC) is required to:**
	• Provide the member with the name and phone number of the CC within 10 calendar days of initial assignment*.
	  ○ This may be done by phone or letter and must be documented in the member's record. If contact is by letter, the CC must use UCare's approved *Welcome Letter – Member in Nursing Home* found on the UCare website.
	  ○ Within the month of enrollment*, but not to exceed 30 days, complete either a new Health Risk Assessment - OR- follow tasks under Transferred Member.
	NOTE: ICF-DD members - For members residing in a group home that are identified as institutional on the care coordination enrollment roster, refer to the Community Care Coordination Requirements Grid, using column "Community Non-Elderly Waiver Members Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI."

ASSESSMENTS	
Health Risk Assessment	A New Member is one that is newly enrolled on UCare MSC+/MSHO. **NOTE:** SNBC members aging into MSC+/MSHO are considered a New Member and need a full MSC+/MSHO Institutional Health Risk Assessment/Support Plan. An annual reassessment is for members who have been assessed in the last 365 days. Members with previous coverage that experience a gap in coverage due to loss of MA* eligibility (e.g., exceeding 90-day grace period) are treated as a NEW member if re-enrolled.
	The CC is required to: **New Member/Initial IHRA*:** • Conduct an initial in-person assessment with member by the 30th day of the month of enrollment using the Institutional Health Risk Assessment/Support Plan. (NOTE: assessments must be in-person effective 1/1/2024). **Annual Reassessment:** • Conduct an in-person assessment with the member within 365 days of the last assessment using the Institutional Health Risk Assessment/Support Plan. (**NOTE**: assessments must be in-person effective 1/1/2024). • Close out the previous year's IHRA/Support Plan (or Care Plan or UTR/Refusal Support Plan if applicable) by updating the column "Date Goal Achieved/Not Achieved," including a month and year. Retain in member's record. **Both initial and reassessments require these tasks:**

	• Complete all sections and questions of IHRA/Support Plan.
	• Review MDS* onsite or if provided hard/electronic copy. If obtained, retain in member's record.
	• List the Interdisciplinary Care Team (ICT) on the IHRA/Support Plan and/or obtain the MDS Signature Page.
	• Review facility's care plan onsite or if provided hard/electronic copy. If obtained, retain in member's record.
	• Document any discussion with the facility if modifications are needed to the facility's care plan.
	• Document assessment of member's desire or ability for relocation back to the community (or indicate as not applicable).
	• Develop person-centered, prioritized goals on the Support Plan for identified areas noted in the IHRA. The CC is not required to develop a goal for identified areas that are not currently active. For example, it is not required to develop goals for identified chronic conditions that are well managed and/or stable.
	  ○ Goals should be written based on needs identified with the member during their assessment.
	  ○ Goals should be written as SMART* goals.
	  ○ Goals should be prioritized using high, medium, or low. At least one goal is ranked as high priority.
	  ○ Interventions should include the necessary steps to achieve the goal (for example, who will provide assistance, and resources/referrals needed to meet the goal).
	• The Support Plan is shared within 30 calendar days of the assessment. Day 1 is the date of the assessment.
	  ○ Share with applicable ICT* members:
	  ▪ Member and/or representative*. Include the UCare *Care Plan Letter.*
	  ▪ PCP* by fax or EMR. (If PCP is onsite, providing Support Plan to facility is sufficient)
	• Enter the assessment on the Monthly Activity Log.

Support Plan Signature Page	**The CC is required to:** • Obtain a signature from the member/representative* on the Support Plan. This signature demonstrates that the CC has discussed the Support Plan with the member/representative. The Support Plan is not considered valid unless signed and dated by the member/representative. • Sign Support Plan signature page and include CC's credentials. • If the signature page is mailed to the member/representative to obtain the signature, document the date of when the signature page was sent. ○ Conduct at least one follow up attempt within 2 weeks of the signature page being sent to the member if the signature page has not been returned to the CC. Document the dates of the follow up.
Transferred Member	A member that previously received MSC+/MSHO care coordination from a UCare delegate and had an IHRA* within the last 365 days. For example, the transfer is between one delegate to another within UCare (Genevive to UCare; UCare to Fairview; Catholic Charities to Genevive). **The enrollment roster does not indicate a change of MCO. Member will have a status of "New Member/Termed Member". Notification of enrollment in a new health plan may come in the following forms when reconciling your roster:**

	• Verifying eligibility in MN-ITS • Notifications from new health plan • Member communication • **NOTE:** After identifying a member is no longer with UCare but is not showing the change on the roster, notify CMIntake@ucare.org. CM Intake will verify and confirm discontinuation of care coordination. **The previous (sending) CC is required to:** • Thoroughly complete the DHS-6037 *Transfer Form* and send via secure email to the new (receiving) CC as soon as the enrollment with the new delegate occurs. The transfer must also include: the most recent IHRA*/Support Plan (or corresponding EMR*/NP* assessment), and other applicable documents. • Refer to the Primary Care Clinic Change section of this grid. **The new (receiving) CC is required to:** • Review transferred documents for completeness and retain in the member's record. • Document this review on IHRA/Support Plan and in the member's record. • If unable to obtain the previous IHRA/Support Plan from the previous (sending) CC, conduct an IHRA/Support Plan by the 30th day of the month of enrollment.
Product Change	An existing UCare member has a Product Change from MSC+ to MSHO or MSHO to MSC+. **NOTE:** A SNBC member aging into MSC+/MSHO will show as a Product Change on the Care Coordination Enrollment Rosters but MUST be considered a New Member. The CC is required to follow the New Member/Initial IHRA steps in the Health Risk Assessment section.

	The CC is required to:
	• Provide the member with the name and phone number of the CC within 10 calendar days of Product Change.
	  ○ This may be done by phone or letter and must be documented in member's record. If contact is by letter, the CC must use UCare's approved MSHO/MSC+ *Welcome Letter – Member in Nursing Home* found on the UCare website.
	• Review the current IHRA*/Support Plan *with* the member by the 30th day of the month of enrollment. This can be done via phone, televideo, or in-person.
	  ○ Review MDS* and facility care plan if available.
	• Document the review on the IHRA/Support Plan in all applicable areas, including comment boxes and in "Monitoring Progress/Goal Revision Date." Add new goals if needed.
	• Make an entry on the Monthly Activity Log.

Mid-Year Review and Ongoing Support Plan Updates	**The CC is required to:**
	• Maintain ongoing contact or check-in with the member mid-year at a minimum to update the IHRA*/Support Plan. This includes the sections "Monitoring Progress/Goal Revision Date" and "Mid-Year and Ongoing Contact Notes". Document date of contact.
	  ○ The contact may be by phone, televideo, or in-person and is the contact is allowed any time 5-7 months from the last assessment date.
	• Update the IHRA/Support Plan every time goals are modified.
	• Make an entry on the Monthly Activity Log under the appropriate columns to represent the IHRA/Support Plan changes.
	  ○ If a member is unable to be reached or refuses the Mid-Year Review, do not add to the Monthly Activity Log.

OBRA Level I	Not applicable for institutionalized members.
Entry of HRA into MMIS	Not applicable for institutionalized members.
OTHER REQUIRED CARE COORDINATOR ACTIVITIES	
Monthly Activity Log	**The CC is required to:** • Enter all MSC+ and MSHO assessments and reassessments on the Monthly Activity Log. • Enter Product Changes on the Monthly Activity Log. • Enter IHRA*/Support Plan modifications on the Monthly Activity Log **when there are changes or updates to member's services, goals, and/or needs**, including at the time of the Mid-Year Review and as a result of a Transition of Care. ○ If a member is unable to be reached or refuses the Mid-Year Review, do not add to the Monthly Activity Log. • Submit the Monthly Activity Log to assessmentreporting@ucare.org by the 10th calendar day of the following month. • See the UCare website for tips and instructions.
Transitions of Care	Transition of Care (TOC) is when a member transitions from one care setting (e.g., member's home, hospital, or skilled nursing facility) to another care setting, whether planned or unplanned. Each transition, when due to a change in the member's health status, is considered a separate transition.
	The CC is required to: • Monitor EAS for admissions on business days. • Monitor the Daily Authorization Report for out-of-state and out-of-network admissions. • Assist with care transitions. • Follow steps below. **MSHO MEMBERS:** • Assist with the member's planned and unplanned transitions from one care setting to another care setting. • Complete the **TOC* Log**, found on the UCare website along with TOC Log instructions.

	○ Contact member/representative* to assist with transition. ▪ When reaching out to the member/representative* for TOC Log tasks, make and document at least 2 actionable attempts*. ○ Share CC contact information and Care Plan/services with receiving setting within one business day of notification of transition. ○ Notify PCP* of transition via fax/phone/EMR/secure email (if PCP was not admitting physician) within one business day of notification of transition. ○ Document reason for admission and all other relevant information on TOC Log. ○ Continue to log subsequent transitions (transition #2, and if applicable, #3, #4, and #5) until member returns to usual setting. • In addition, the below tasks should be completed when the member discharges TO their usual care setting. This includes situations where it may be a 'new' usual care setting for the member (i.e., a community member who decides upon permanent nursing home placement). ○ Communicate with member/representative about care transition process, changes to the member's health status, and support plan updates within 1 business day of notification of transition. ○ Provide education about transitions and how to prevent unplanned transitions/readmissions. ○ Complete 4 Pillars for Optimal Transition ▪ Indicate if the member has a follow-up appointment scheduled with primary care or specialist. If not, provide explanation in comments. • For mental health hospitalizations, indicate if the member has a follow-up appointment scheduled with a mental health practitioner within 7 days of discharge. ▪ Indicate if the member can manage their medications or has a system in place to manage medications. If not, provide explanation in comments. ▪ Indicate if member can verbalize warning signs and symptoms and how to respond. If not, provide explanation in comments. ▪ Indicate if the member uses a Personal Health Care Record. If not, provide explanation in comments. ○ Indicate whether the member's Care Plan has been updated following this transition. If not, provide explanation in comments. ▪ Indicate whether you have reviewed the discharge summary with the member. If not, provide explanation in comments.

	• Conduct a Change in Condition* assessment in the event of a care transition when a member experiences significant health changes, repeated or multiple falls, recurring hospital readmissions, or recurring emergency room visits. • If the TOC resulted in a change to member's services, goals, and/or needs, enter the Care Plan modifications on the Monthly Activity Log. **NOTE:** If the CC is notified of the transition(s) 15 days or more after the member has returned to their usual care setting, the CC is not required to complete a TOC Log. However, the **CC is still required to:** ○ Follow-up with the member to discuss the care transition process, any changes to their health status, and their Care Plan. ○ Provide education about how to prevent a readmission and document this discussion in the case notes. ○ When reaching out to the member/representative*, make and document at least 2 actionable attempts*. ○ The 15-day exception only applies if the CC finds out about *all* the transitions after the member has returned to their usual care setting. **MSC+ MEMBERS** • Upon return to usual setting, follow-up with the member to discuss the transition, any changes to their health status, and/or changes to their Support Plan. Use Transition of Care Talking Points on the UCare website. ○ When reaching out to the member/representative*, make and document at least 2 actionable attempts*. • Provide education about how to prevent a readmission and document this discussion in the case notes. • If the TOC resulted in a change to member's services, goals, and/or needs, enter the Care Plan modifications on the Monthly Activity Log. • Conduct a Change in Condition* assessment in the event of a care transition when a member experiences significant health changes, repeated or multiple falls, recurring hospital readmissions, or recurring emergency room visits. • Use professional judgement to determine additional care coordination intervention.
Member Death	**The CC is required to:** • Submit a Member Death Notification Form to UCare. • Send the DHS-5181 *Lead Agency Assessor/Case Manager/Worker LTC Communication Form* to the County of Financial Responsibility (CFR).
Advance Directives	**The CC is required to:** • Document on an annual basis that Advance Directives were discussed with the member. • If Advance Directives were not discussed, document the reason.

Annual Preventative Care	**The CC is required to:** • Document on the IHRA*/Support Plan form that a conversation was initiated with the member and/or facility staff regarding preventive health care (e.g., pneumovax, flu shot, dental visit, vision evaluation). • If a preventive screening is due/overdue, note the reason why and/or document CC's follow up activities.
ICT* Collaboration	**The CC is required to:** • Ensure the facility care plan employs an interdisciplinary approach by incorporating the unique primary, acute, long-term care, mental health, and social service needs of each member with appropriate coordination and communication across all providers. • Document a list of members of the ICT (from the ICT section of the MDS*) in the member's file.

Actions When Member Discharges to Community	**The CC is required to:**
	Refer to MSC+/MSHO Community Requirements Grid:
	• When using MnCHOICES* Assessments, use the MSC+/MSHO Community Requirements Grid (MnCHOICES version)
	  ○ Complete Initial Assessment (either Health Risk Assessment-MCO or MCO-MnCHOICES Assessment).
	• When using 3428/3428H assessments, refer to the MSC+/MSHO Community Requirements Grid.
	  ○ Choose the applicable column: "Community Non-Elderly Waiver Members-Includes: Non-Elderly Waiver with PCA and CAC/CADI/DD/BI" or "Community Elderly Waiver Members." Follow guidelines for Initial Assessment.

Medical Assistance Eligibility Renewals	**The CC is strongly encouraged to:** • Remind members when they are at risk of losing Medical Assistance (MA*) eligibility due to failure to complete and return paperwork. • Assist members with the completion of renewal paperwork as appropriate. **NOTE:** The UCare Keep Your Coverage Team reaches out to members to offer additional assistance with maintaining eligibility. The CC may collaborate with the Keep Your Coverage Team for support.
90 Day Grace Period After MA* Terms	**If a member's Medical Assistance terms the CC is required to:** • Monitor MN-ITS monthly for 90 days. • Complete any assessments that are needed in the following 90 days. • Continue all care coordination tasks for the 90 days following MA* termination. • Retain the completed assessment documents in the member's record. • Enter the assessment data on the Monthly Activity Log once MA is reinstated.
Member Change of Address	**The CC is required to:** • Send the DHS-5181 *Communication Form* to the County of Financial Responsibility (CFR) as notification of the member's new address and the date they moved. ○ Maintain a copy of the form and document the action in the member's record.

Primary Care Clinic Change	**If there is a change to the onsite physician or the member changes primary physicians, resulting in a change of care coordination entities, the current (sending) CC completes the following tasks:**
	• Confirm Primary Care Clinic with the member:
	  ○ Confirmation needs to be a verbal discussion with the member.
	  ▪ Reviewing EMR* or Internal Systems to see if the member has established care is NOT sufficient.
	  ○ If the member states they plan to establish care with a new clinic, UCare expects the new (receiving) CC to work with the member in scheduling the appointment to establish care. Ensure the desired clinic is in UCare's provider network, if not, the current CC will work with the member to establish care at an in-network provider, prior to completing a *Primary Care Clinic Change Request* form.
	• Ensure the member does not have a future MA* end date as these members cannot be transferred.
	• **When a PCC Change Form will initiate a transfer to a new UCare Care Coordination delegate, all required assessments and corresponding paperwork/documentation must be fully completed prior to a transfer. Members cannot be transferred the month their annual assessment is due. The current (sending) CC must complete all assessment paperwork PRIOR to transfer, including, but not limited to, all EW paperwork (e.g., 3543, 5181, WSAFs).**
	• CC's should not initiate the PCC Change during a TOC*.
	• If the member is new or is a member with a Product Change: Complete the *Primary Care Clinic (PCC*) Change Request* form and submit to UCare no later than the 12th of the month for a retro assignment.
	• If this is an ongoing member (NOT New or had a Product Change), complete the *Primary Care Clinic (PCC*) Change Request* form and submit to UCare no later than the 24th of the month prior to the transfer effective date.
	• UCare will notify the current (sending) CC if the transfer has been denied.
	• The current (sending) CC/entity is responsible for care coordination until the transfer effective date indicated on the *PCC Change Request* form.
	• The current (sending) CC completes the DHS-6037 *Transfer Form* and sends to the new (receiving) CC/entity, along with all pertinent documents.
	• Care coordination entities and delegates are strongly encouraged to reconcile their care coordination enrollment rosters monthly.

Behavioral Health Home (BHH) Services	**The CC is required to:**
	• Contact BHH provider within 30 business days of notification that the member is receiving BHH. During this call, the CC will:
	  ○ Provide the BHH provider with the CC's contact information.
	  ○ Share information related to the members Support Plan.
	  ○ Establish contact frequency between BHH provider and CC and preferred method of communication.
	• Include BHH service on the member's Support Plan.
	• Include BHH provider as ICT.
	• Notify BHH staff of any known ER/hospitalization admission and/or discharge.
	• Notify BHH staff of any transitions of care, post discharge plans and follow up plans.
	• Document all contact with BHH provider in the member's record.

Coordination With Local Agencies	**The CC is required to:**
	• Make referrals and/or coordinate care with county social services and other community resources per member's needs, including but not limited to:
	  ○ Pre-petition Screening.
	  ○ OBRA Level II referral for Mental Health and Developmental Disability.
	  ○ Spousal Impoverishment Assessments.
	  ○ Adult Foster Care.
	  ○ Group Residential Housing Room and Board Payments.
	  ○ Substance Use Disorder room and board services covered by the Consolidated Chemical Dependency Treatment Fund.
	  ○ Adult Protection.
	  ○ Local Human Service Agencies for assessment and evaluation related to judicial proceedings.

MSHO Model of Care Training	UCare requires that all CCs complete the Model of Care training within three months of hire and annually thereafter. CCs may access this training via WebEx located on the UCare Care Management/Care Coordination website (titled MSHO & UCare Connect + Medicare MOC Training). UCare will also provide Model of Care training to CCs on an annual basis. • Each CC will need to submit the electronic attestation form following the completion of training located on the UCare Care Management/Care Coordination website.

Documentation and Notes	**The CC is required to document in the member's file all evidence of:** • Care coordination requirements are being met. • Care coordination requirements that were attempted but not completed. • Member documents including, but not limited to, IHRA*/Support Plans, nursing facility care plans, visiting physician notes, medication lists, MDS*, and TOC* Logs.
DTR Requirements	Denial, Termination, Reduction (DTR) of medically necessary services. • UCare (or one of its utilization review delegates) must review all services that require a medical necessity review. UCare issues a DTR letter to the member any time services that require prior authorization and review of medical necessity according to UCare's prior authorization grid are denied, terminated, or reduced. DTR of these services requires review and determination by a Medical Director.
Policies & Procedures	UCare and all care coordination delegates are required to have policies and/or procedures that support all the above stated requirements.

*DEFINITIONS/ACRONYMS	
Term/Acronym	**Definition**
Actionable Attempts	Successful communication that the member can act upon. For example, a voicemail left at a known number for the member, mailing a letter to a known address, or sending a secure email to a verified email address for the member/representative. When mailing UTR letters, allow at least 2 days in between mailings to allow time for member to respond. Ideally, attempts are 3 calls and one letter. If calls are not actionable (e.g., number unconfirmed/not working), then additional letters are acceptable. **NOTE:** Investigative research* is not considered at actionable attempt.
Assignment Date	When a member is assigned to a care coordination delegate via the monthly enrollment roster.
EMR	Electronic Medical Record
Change in Condition	UCare requires CCs to conduct an additional assessment in the event of a significant change in a member's condition, including care transitions that involved significant health changes, repeated or multiple falls, recurring hospital readmissions, or recurring emergency room visits. All CCs are Qualified Professionals*, and UCare depends on the use of their clinical, professional judgment to determine whether a change in condition or care transition warrants a reassessment. In addition, members or their representative may request a comprehensive assessment to determine waiver eligibility, and UCare must provide this within 20 calendar days of the request.
EAS	Encounter Alert Services – allows providers throughout the state to receive member encounter alerts, for individuals who have been admitted to, discharged, or transferred from, an EAS-participating hospital, emergency department, long-term care facility, or other provider organization in real time.

Enrollment Date	First day of the month the member enrolls to the current health plan product.
ICT	Interdisciplinary Care Team: • At a minimum includes the Care Coordinator, the member and/or representative*, caregiver (as applicable), and the PCP. • ICT members may also include all other health and service providers (including Managed Long Term Supports & Service providers/Home & Community Based Service providers) as needed, if they are involved in the member's care for current health conditions. ○ These may include but are not limited to: specialty care providers, social workers, mental health providers, nursing facility staff, and others performing a variety of specialized functions designed to meet the member's physical, emotional, and psychological needs.
IHRA	Institutional Health Risk Assessment
Investigative Research	A good faith effort should be documented to locate a member's contact information. Investigative research is not considered an actionable attempt*. Examples may include: • Contact Financial Worker for correct contact or a number for an Authorized Representative • Contact PCC* • Contact nursing facility staff • Review historical information – check to see if previous number is now working • As available – utilize authorizations or other electronic health records accessible to the County or Care System (MIIC, EPIC, EHR).
MA	Medical Assistance
MDS	Minimum Data Set: Screening and assessment tool for residents of long-term care facilities.
MMIS	Medicaid Management Information System: Minnesota's automated system for payment of medical claims and capitation payments for Minnesota Health Care Programs (MHCP).
MnCHOICES	A single, comprehensive, web-based application that integrates assessment and support planning for all people who seek access to Minnesota's long-term services and supports.
MN-ITS	DHS system care coordinators use to verify member MA status, Medicare, Waiver, MCO and Restricted Recipient eligibility. MN-ITS is also the DHS billing system for providers enrolled in Minnesota Health Care Programs (MHCP). UCare suggests checking MN-ITS to verify member's eligibility status upon initial assignment and every 6 months thereafter.
NP	Nurse Practitioner
PCC	Primary Care Clinic
PCP	Primary Care Physician

Qualified Professional	Must hold a Minnesota licensure (Licensed Social Worker, Registered Nurse, Physician Assistant, Nurse Practitioner, Public Health Nurse, or physician) with the exception of County Social Worker, who are employed by the county.
Rate Cell	Rate Cell A = Community, non-Elderly Waiver Rate Cell B = Community, Elderly Waiver Rate Cell D = Institutional
Representative	**A members verified legal alternative decision maker. For example: court appointed guardian/conservator, health care agent. Obtain a copy of guardian/conservator or Health Care Directive documents to verify level of representation.** **Examples of alternative decision makers, but not limited to:** **Guardian** is "A person with the legal authority and duty to act on behalf of another person. The legal guardian can make decisions for the person about where to live, medical treatment, training and education, etc. Decision-making is limited to the specific powers the court assigns to the legal guardian (dhs.state.mn.us)." **Health Care Agent** is the person listed on a Health Care Directive that can make health care decisions if the individual is unable to make those decisions (MDH, Health Care Directives - Minnesota Dept. of Health (state.mn.us)). A designated health care agent may sign ROI, only if the principal is unable to sign for themselves, unless explicitly directed in the Health Care Directive. **Power of Attorney (POA)** "is a written document often used when someone wants another adult to handle their financial or property matters (Minnesota Judicial Branch, Power of Attorney, Minnesota Judicial Branch - Power of Attorney (mncourts.gov))." POA will cease when a person becomes incapacitated. • **Durable Power of Attorney** hold the same privileges as POA but maintains their power through incapacities and terminates upon death of the member. **Authorized Representative (A-Rep)** is "a person or organization authorized by an applicant or enrollee to apply for a MHCP and to perform the duties required to establish and maintain eligibility (DHS, Eligibility Policy Manual, 1.3.1.2 MHCP Authorized Representative (state.mn.us)." This type of representative is exclusive to financial eligibility such as Medical Assistance eligibility and MHCP Eligibility. **Responsible Party (RP)** is "A person who is at least 18 years old and capable of providing the support necessary to help the person receiving PCA services to live in the community when the person is assessed as unable to direct their own care (DHS, PCA Manual, PCA responsible party (state.mn.us))." This type of representative is exclusive to PCA. The designated RP is not permitted to act as the PCA.
ROI	Release of Information
SMART Goals	Specific, Measurable, Attainable, Relevant, and Timebound. Find more information on the UCare website.
TOC	Transition of Care

DHS eDocs	
eDocs	**Title of document and short descriptions**
DHS-3426	*OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness* This form should be completed during all assessments. It specifically is for when a person seeks admission to a Medical Assistance-certified nursing or boarding care facility or as part of a community assessment.
DHS-3428	*Minnesota Long Term Care Consultation (LTCC) Services Assessment Form* This form is used by lead agencies to record LTC assessments. **NOTE:** When completing the LTCC, all questions and sections must be completed or marked as "Not Applicable." This includes: ○ Informal Caregiver Assessment if section "E" demonstrates need for a caregiver. ○ My Move Plan Summary, if "Prefer to live somewhere else" or "Don't know" on question E.13.
DHS-3428D	*Supplemental Waiver PCA Assessment and Service Plan* Lead agencies use this form when assessing for PCA services for people on HCBS waiver and the Alternative Care Program.
DHS-3936	*My Move Plan Summary Form* When a person who receives long-term services and supports is moving to a new residence, he or she completes the My Move Plan Summary (DHS-3936) form with case manager/support planner.
DHS-5181	*Lead Agency Assessor/Case Manager/Worker LTC Communication Form* This form is to be used by lead agency case managers and workers to ensure that the process to determine if applicants or enrollees are eligible to receive MA* payments for services received through the HCBS waiver program is initiated promptly. It is also used to communicate change of member's address, member death, and care coordinator changes.
DHS-6037	*HCBS Waiver, AC, and ECS Case Management Transfer and Communication Form* This form assists health plan, county, and tribal care coordinators and case managers to share information.
DHS-7028	*Nursing Facility Level of Care Criteria Guide* Determines institutional level of care (including nursing facility NF-LOC). A member must meet the criteria to be eligible for Elderly Waiver.
DHS-8354	*MCO Member Address Change Report Form* **Online portal only:** https://edocs.mn.gov/forms/DHS-8354-ENG Link for care coordinators to report address changes to the county. For care coordination use only.