MHM – Moving Home Minnesota Process Flow

Definition

- Federal demonstration project known as Money Follows the Person (MFP).
- Goal is to create opportunities for members to move from an institutional setting into their own residence in the community.
- MHM promotes transition plans that meet the members need in an integrated setting.

Eligibility

- Resident of MN
- Any age or disability group
- Eligible for Medical Assistance (MA) prior to discharge and maintain eligibility post discharge
- 90 day stay or more in a qualified institution (i.e. nursing facility, hospital)
    - Medicare-paid days do not count toward the 90 day requirement
    - The 90 day requirement may be fulfilled through sequential stays in multiple qualified institutions
        - Example: Member may start out in a MA-paid hospital, and then move to a facility providing rehabilitation services paid by Medicare, then to a nursing facility paid by MA. The stay is regarded as continuous, but only the MA-paid days count toward the 90 day requirement.

Approval

- Care Coordinator, member, family member, nursing facility staff or any other invested person with member permission can make a referral to the Department of Human Services (DHS). Methods to apply:
    - **MHM Intake Form DHS-5032**
    - Mail: PO Box 64250, St Paul, MN 55164
    - Fax: 651-431-7745
    - Phone
        - Disability Hub MN: 800-333-2466
        - Senior Linkage Line: 800-333-2433
        - MHM Intake: 651-431-3951
- DHS determines member eligibility and will communicate next steps to the UCare MHM liaison.
- UCare MHM liaison will contact the assigned CC and provide information regarding next steps (i.e. informed consent, LTCC) and resources.

Transition Coordination Services

- CC works with member and/or institutional setting to complete the **Informed Consent (DHS-6759I-ENG)** and fax directly to MHM, 651-431-7745
- If applicable, CC completes the **LTCC/DHS-3428-ENG** (current within the past 12 months) to determine member Nursing Facility Level of Care (NFLOC) and fax directly to MHM, 651-431-7745. DO NOT enter LTCC in MMIS. Reminder – ensure G22 reflects "Y" to indicate member will be participating in the MHM program.
- Once member is officially approved for MHM, the UCare MHM Liaison will provide referral forms for Transition Coordination Services (TCS) to the assigned CC and complete the referral process with the TCS provider.
- UCare utilizes the following providers for TCS:
  - ✓ Options For Independence | Provider ID# 213500 | Phone: 612-216-4687
  - ✓ Promise Transition Services | Provider ID# 221006 | Phone: 612-236-7979
  - ✓ Superior Health & Human Services | Provider ID# 203197 | Phone: 651-705-8723
  - ✓ Exodus | Provider ID#226888 | Phone: 952-687-9994
- Transition Coordinator and member will complete the following tools/forms:
  - **Transition Planning Tool (DHS-6759J)**, which includes person-centered requirements.
  - **Transition Planning Tool Part 2: Risk Mitigation (DHS-6759K),** when no other risk mitigation process is in place.
  - **Housing Transitions Worksheet (DHS-6759G)**, which includes member information and housing needs in the community.
- Transition Coordinator and member will complete all necessary paperwork for housing applications which includes but is not limited to, accompany member to sign lease, pay deposit, purchase needed furnishings, arrange for delivery, etc.
- Transition Coordinator will use **MHM Communication Form (DHS-6759H-ENG)** to notify DHS once an estimated date for move is identified. DHS will verify that housing meets qualifications and is affordable for member.

Transition:

- Transition Coordinator and CC will coordinate home care services, supplies, equipment, social, religious, and recreational supports as needed. Transition Coordinator meets member at new residence on moving day. CC assures that medications, required services, etc. are in place.
- Transition Coordinator completes **MHM Communication Form (DHS-6759H)** to notify DHS with official transition date, address of community setting and type of

community setting (i.e. Customized Living, Adult Foster Care, independent apartment).

Resources:

- **UCare MHM Liaison**
  - Dee-Ana Farness, MSHO/MSC+ Care Management Supervisor
    - Phone: 612-294-5781
    - Email: dfarness@ucare.org
- **MHM Program Manual**
- **Relocation Service Coordination Certified Provider List**
- **Program Contact Info:**

  Minnesota Department of Human Services, Moving Home Minnesota
  - Email: movinghomemn.mfp@state.mn.us
  - Phone: 651-431-3951 or 888-240-4756
  - Fax: 651-431-7745
- **eDocs**

Authorizations:

- No authorization is required for Transition Coordination Services.
- CC will complete a Waiver Service Approval Form (WSAF) for waiver funded items (i.e. Transitional Services); please utilize the codes specific for MHM per DHS service rate
- See Moving Home Minnesota Demonstration and Supplemental Services Table