Employment and Community First CHOICES Safety Determination Request Form

Applicant Name: _____

SSN: _____ DOB: _____ Age _____

This form is to be used only by an MCO or DIDD submitting a PAE for NF LOC and requesting a Safety Determination in accordance with requirements set forth in TennCare Rule. This form must be completed in its entirety and included with the PAE submission, along with all required documentation as specified below. An incomplete Safety Determination Request Form, or a Safety Determination Form submitted without documentation as specified below, will be denied.

Total Acuity Score of PAE as submitted: _____

Current Living Arrangements:

Applicant residence:

- ☐ Lives in own home alone
- ☐ Lives in own home with parents
- ☐ Lives at home with other family —specify relationship_____
- ☐ Lives at home with others— specify relationship _____
- ☐ Lives in other's home—specify relationship _____
- ☐ Lives in a community-based residential setting—specify_____
- ☐ Other—specify_____

Justification for Safety Determination Request:

Please note that documentation as specified below may consist of, but is not limited to, narrative descriptions or explanations from submitter, caregivers, or family members; hospital notes, therapy notes, MD visits, ADL flow sheets, encounter notes from nurses, therapists, or physicians; and any other documents which would demonstrate the safety concern(s) for the applicant.

- ☐ Applicant has an intellectual or developmental disability and a General Maladaptive Index value of -31 or lower

  Please attach copy of Maladaptive Behavior Assessment and Score and label **MBA and MBI**.

STOP: if above box is checked please go directly to Page 9, complete the attestation and submit the ECF CHOICES Safety Determination Form. If the box is not checked, please proceed with the remaining sections of the form.

Please check and complete **all** that apply. While a single justification is sufficient for review of a Safety Determination request, it is critical that TennCare has benefit of all available information pertaining to safety concerns that could impact the applicant's ability to be safely served in Groups 4 or 5, as applicable.

- ☐ The applicant has an intellectual or developmental disability and is under the age of 18 and will not qualify financially for TennCare unless the deeming of the parent's income to the child is waived, and absent the availability of benefits in ECF CHOICES Group 4, the child is at imminent risk of placement outside the home (DIDD use only).

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Please explain how such event(s) or circumstances would impact the Applicant's ability to remain in the family home:

_____
_____
_____
_____
_____

Please explain how benefits in ECF CHOICES Group 4 would help the child stay in the home:

_____
_____
_____
_____

☐ Applicant has an intellectual or developmental disability and a General Maladaptive Index value of -21 or lower

Please attach copy of Maladaptive Behavior Assessment and Score and label **MBA and MBI**.

☐ The applicant has an approved acuity score of at least five (5) but no more than eight (8)

☐ The applicant has an individual acuity score of at least 2 for the Behavior measure **and** the absence of intervention and supervision for behaviors at the frequency specified in the PAE would result in imminent and serious risk of harm to the Applicant and/or others.

- Provide a detailed description of the specific behavior(s), the frequency of each behavior, and information and/ or examples which support and describe the imminence and seriousness of risk resulting from the behavior(s). (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant's behavior deficit. Label attachment(s) as "**Behavior Deficit**.")

_____
_____
_____
_____
Description of documentation attached:_____ _____

☐ The applicant has an individual acuity score of at least 3 for the Orientation measure **and** the absence of frequent intermittent or continuous intervention and supervision would result in imminent and serious risk of harm to the applicant and/or others.

- Provide a detailed description of how orientation deficits impact the applicant's safety, including information or examples that would support and describe the imminence and seriousness of risk.

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(Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant's orientation deficit. Label attachment(s) as "**Orientation Deficit**.")

_____
_____
_____
_____

Description of documentation attached: _____

☐ The applicant has an individual acuity score of at least 3 for the mobility or transfer measures **and** the absence of frequent intermittent assistance for mobility or transfer needs would result in imminent and serious risk to the applicant's health and safety.

- Describe how often mobility and/or transfer assistance is needed by the member and the availability of paid and unpaid caregivers to provide such assistance, including any recent changes in the applicant's needs and/or availability of caregivers to meet such needs. (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant's mobility or transfer deficit. Label attachment(s) as "**Mobility or Transfer Deficit**.")

_____
_____
_____
_____

Description of documentation attached: _____

☐ The applicant has an individual acuity score of at least 2 for the toileting measure, **and** the absence of frequent intermittent assistance for toileting needs would result in imminent and serious risk to the applicant's health and safety.

- Describe how often toileting assistance is needed by the member and the availability of paid and unpaid caregivers to provide such assistance, including any recent changes in the applicant's needs and/or availability of caregivers to meet such needs. (Attach additional explanation if needed and any other documentation which would support safety concerns pertaining to the applicant's toileting deficit. Label attachment(s) as "**Toileting Deficit**.")

_____
_____
_____
_____

Description of documentation attached: _____

☐ **The applicant** has experienced a significant change in physical or behavioral health or functional needs.

- Provide a detailed description of the change(s), and how such changes impact the applicant's need for assistance. (Attach additional explanation if needed and any other documentation which would support

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that these change(s) occurred and/or concerns pertaining to the applicant's safety as a result of the change(s). Label attachment(s) as "**Change in Needs**.")

_____

_____

_____

_____

Description of documentation attached: _____

☐ Applicant's **primary caregiver** has experienced a significant change in physical or behavioral health or functional needs which impacts the availability of needed assistance for the applicant.

- Provide a detailed description of the change(s), and how such changes impact the availability of needed assistance for the applicant. (Attach additional explanation if needed and any other documentation which would support that these changes occurred and/or concerns pertaining to the applicant's safety as a result of the change(s). Label attachment(s) as "**Change in Primary Caregiver Status**.")

_____

_____

_____

_____

Description of documentation attached: _____

☐ Applicant has a pattern of recent falls resulting in injury or with significant potential for injury or a recent fall under circumstances indicating a significant potential risk for further falls.

- Provide a detailed description of the fall(s) including the date of each incident, circumstances surrounding each fall, injury sustained as a result of the fall (if applicable) or significant potential for injury or risk for further falls, treatment received (if applicable), and interventions implemented to mitigate the risk of falls and injury from falls, and whether these interventions have been successful. (Attach additional explanation if needed and any other documentation pertaining to fall(s), including documentation of any treatment received. TennCare developed Fall Form may be used to assist. Label attachment(s) as "**Documentation of Falls**.")

_____

_____

_____

_____

Description of documentation attached:_____

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☐ Applicant has an established pattern of recent emergent hospital admissions or emergency department utilization for emergent conditions or a recent hospital or NF admission or episode of treatment in a hospital emergency department under circumstances sufficient to indicate that the person may not be capable of being safely maintained in the community (not every hospital or NF admission or ER episode will be sufficient to indicate such).

- Document below and provide detailed explanation of any circumstances pertaining to such inpatient admission(s) or ER visit(s) which indicate that the person may not be capable of being safely maintained in the community, along with records from each admission or ER visit, e.g., discharge papers. Label attachment(s) as "**Inpatient Admissions/ER Visits**."

Recent (last 365 days) hospital admissions		
Admit Date	Discharge Date	Reason for Admission

Recent (last 365 days) ER visits (for emergent condition *only*)	
Date	Reason for ER visit

Recent (last 365 days) nursing facility admissions		
Admit Date	Discharge Date	Reason for admission

Description of documentation attached: _____

☐ The applicant's behaviors or a pattern of self-neglect has created a risk to personal health, safety and/or welfare requiring involvement by law enforcement or Adult Protective Services.

- Provide a detailed description of the behaviors and/or pattern of self-neglect, the frequency of each such behavior or self-neglect, the risk to personal health, safety and/or welfare, the date of involvement by law enforcement or Adult Protective Services, and any actions taken by such agency to ensure the

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person's safety. Attach supporting documentation, including the APS/ Police reports, where available. Label attachment(s) as "**APS/Police Involvement**."

_____

_____

_____

_____

Description of documentation attached: _____

☐ The applicant has recently been discharged from a community-based residential alternative setting (or such discharge is pending) because the applicant's needs can no longer be safety met in that setting.

- Document below and attach documentation detailed description of the circumstances leading to discharge, including documentation from the CBRA. Include explanation regarding any other previous settings from which the applicant has been discharged due to safety concerns, including the date(s) of such admissions and discharge. Label attachment(s) as "**CBRA Discharge**."

Name of CBRA facility: _____

Date of discharge: _____

Safety concerns leading to discharge_____

_____

_____

_____

Description of documentation attached: _____

☐ The applicant has diagnosed complex acute or chronic medical conditions which require frequent, ongoing skilled and / or rehabilitative interventions and treatment by licensed professional staff.

- Document below (attach additional explanation if needed) and attach current (last 365 days) medical records documenting each condition, including ongoing treatment prescribed, and the name, professional title, and contact information of the primary treating practitioner for each such condition:

Medical Condition	Acute or Chronic	Intervention Required	Licensed staff required

Description of documentation attached: _____

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- ☐ The applicant's MCO has determined, upon enrollment into Group 5 based on a PAE submitted by another entity, that the applicant's needs cannot be safely met within the array of services and supports available if enrolled in Group 5.
- ☐ None of the criteria above have been met, but other safety concerns which impact the applicant being safely served in CHOICES Group 5 exist.
    - Provide a detailed description of the safety concern and include sufficient evidence showing that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in Choices Group 5. (Attach additional explanation if needed and any other documentation which would support the safety concerns detailed below. Label attachment(s) as "**Other Safety Concerns**.")

      _____

      _____

      _____

      _____

    Description of documentation attached: _____

Additional Required Documentation:

In addition to the information specified above to support each of the safety concerns identified, unless the applicant has a maladaptive score of -31 or lower, you must attach:

- ✓ A comprehensive needs assessment, including:
    - ✓ an assessment of the applicant's physical, behavioral, and psychosocial needs not reflected in the PAE;
    - ✓ the specific tasks and functions for which assistance is needed by the Applicant;
    - ✓ the frequency with which such tasks must be performed; and
    - ✓ the Applicant's need for safety monitoring and supervision

  Label attachment(s) as "**Comprehensive Needs Assessment**."

- ✓ A detailed description of the Applicant's living arrangements and the services and supports the Applicant has received during the six (6) months prior to submission of the Safety Determination request, including unpaid care provided by family members and other caregivers, paid services and supports the Applicant has been receiving regardless of payer (e.g., non-CHOICES HCBS available through TennCare such as home health and services available through Medicare, private insurance or other funding sources); and any anticipated change in the availability of such care or services from the current caregiver or payer

  Label attachment(s) as "**Prior 6 Months**."

- ✓ A detailed explanation regarding any recent significant event(s) or circumstances that have impacted the Applicant's need for services and supports, including how such event(s) or circumstances impact the Applicant's ability to be safely supported within the array of covered services and supports that would be available if the Applicant were enrolled in CHOICES Group 5 or for a child under age 18 who has an intellectual or

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developmental disability, how such event(s) or circumstances would impact the Applicant's ability to remain in the family home.

Label attachment(s) as "**Recent Events**."

- ✓ A person-centered plan of care or support plan developed by the MCO Care Coordinator or Support Coordinator (i.e., the entity submitting the Safety Determination request) which specifies the tasks and functions for which assistance is needed by the Applicant, the frequency with which such tasks must be performed, the Applicant's need for safety monitoring and supervision; and the amount (e.g., minutes, hours, etc.) of paid assistance that would be necessary to provide such assistance; and that would be provided by such entity upon approval of the Safety Determination. A plan of care or support plan is not required for a Safety Determination submitted by DIDD.)

  Label attachment(s) as "**Plan of Care** or **Support Plan**."

- ✓ A detailed explanation regarding why the array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of $30,000 and one-time emergency assistance up to $6,000 and non- CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the applicant's needs in the community or for a child under age 18 who has an intellectual or developmental disability, why the availability of benefits in ECF CHOICES Group 4, including ECF CHOICES HCBS up to the Expenditure Cap of $15,000, non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, will help to minimize the child's risk of risk of placement outside the home.

  Label attachment(s) as "**Safety Explanation**."

- ✓ If an Emergent Criteria Review Form has been completed and approved by Interagency Committee Review for this Applicant, please attach the completed **Emergent Criteria Review Form** and **Interagency Committee Review Decision Form**.
- ✓ If a Multiple Complex Health Conditions Criteria Review Form has been completed and approved by Interagency Committee Review for this Applicant, please attach the completed **Multiple Complex Health Conditions Criteria Review Form** and **Interagency Committee Review Decision Form**.

  Label attachments as **"Interagency Review and Decision."**

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Submitting Entity Attestation

Completed Attestation, printed name, signature, credentials and date of form completion are required.

Please read and check at least one of the statements below (check all that apply):

- ☐ I believe this individual, who is under 18 with an intellectual and/or developmental disability, is at imminent risk of placement outside the home without the availability of benefits in ECF Choices Group 4.
- ☐ I do **not** believe this individual can be safely served in the community in CHOICES Group 5.
- ☐ I believe this individual **can** be safely served in the community in CHOICES Group 5.
- ☐ This safety determination form was completed at the request of the applicant/representative.

By signing below, I, as a qualified assessor, take responsibility for the information provided in this Safety Determination request and attest that I have personally reviewed the information provided in this Safety Determination Request and it is accurate and true to the best of my knowledge. I understand that this information will be used to determine Medicaid reimbursement for long-term care services and/or the applicant's Medicaid eligibility. I understand that any intentional act or omission on my part to provide false information or give a false impression that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled may be considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent may be subject to federal and state civil and criminal penalties.

_____ _____

Printed Name of person making this decision Signature of person making this decision

_____ _____

Qualified Assessor Code Date

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Fall Form

Please use this form when the justification for a safety determination request is related to a recent fall(s). Provide any available information for falls occurring within the last 6 months. Most recent fall should be listed first. All fields are not required, but providing all the details available will help ensure that the correct LOC is approved for this person.

Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc…)			
Was an injury sustained related to fall? YES / NO	If yes, describe:		
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc…)			
Was an injury sustained related to fall? YES / NO	If yes, describe:		
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc…)			
Was an injury sustained related to fall? YES / NO	If yes, describe:		
What mechanisms are in place to prevent falls?			

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Why were these prevention mechanisms unsuccessful?			
Fall #	Date of fall:	Time of Fall:	AM / PM
Location of Fall:			
What was applicant doing prior to fall?			
List factors contributing to fall (environment, meds, etc…)			
Was an injury sustained related to fall? YES / NO		If yes, describe:	
What mechanisms are in place to prevent falls?			
Why were these prevention mechanisms unsuccessful?			