TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

InReach Reference Manual

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DIRECT INTERVENTION: VITAL EARLY RESPONSIVE TREATMENT SYSTEMS (DIVERTS)

The DBHDID In-Reach Manual provides comprehensive guidance on implementing the Direct Intervention: Vital Early Responsive Treatment Systems (DIVERTS) program. Created in response to the evolving needs of the adult System of Care (SOC), this manual serves as a crucial resource for professionals dedicated to fostering community-based interventions and support systems. Tailored to meet the needs of our diverse audience, including case managers, clinicians, and program administrators, this manual offers a structured approach to navigating the complexities of the DIVERTS program. By outlining key strategies, best practices, and protocols, this manual aims to empower our stakeholders to effectively address the challenges individuals face within the SOC. Through collaborative efforts and a commitment to excellence, we aspire to enhance the quality of care and promote holistic wellness within our communities.

DIVERTS was implemented by the Cabinet for Health and Family Services (CHFS) in 2013 to:

- Develop an organized system of care for adults with Serious Mental Illness (SMI).
- Expand specialty mental health care (e.g., evidence-based mental health practices).
- Require Community Mental Health Centers (CMHCs) to develop specialty services (e.g., Assertive Community Treatment).
- Ensure a minimum set of services across all 14 CMHCs.

DIVERTS has gone through many updates since its inception in Kentucky, and the minimum set of services has been established across all 14 CMHCs.

This DIVERTS program description is included in the FY25 CMHC contract (subject to change in subsequent fiscal years):

"DIVERTS shall be offered to adults with serious mental illness (SMI) who are institutionalized or at risk of institutionalization, regardless of payor. DIVERTS services shall be developed and made available to assist persons with SMI in transitioning to living in integrated settings in the community while receiving appropriate treatment and support services. These services will help with recovery while preventing admission and/or re-admission to psychiatric institutions or other congregate settings. The DIVERTS program supports the goals of the Third Amended Settlement Agreement (TASA). Refer to the DBHDID website for a copy of the TASA and 908 KAR 2:065, Community Transition for Individuals with Serious Mental Illness."

DIVERTS PROGRAMS AND INITIATIVES

All programs and services listed under DIVERTS below may be provided as stand-alone services through DIVERTS funding. They need not be components of Assertive Community Treatment (ACT), even though they could all be completed as part of ACT services.

Assertive Community Treatment (ACT): This is an evidence-based team approach to the provision of treatment, rehabilitation, and support services to adults with serious mental illness. ACT consists of multidisciplinary staff organized as a team whose members function interchangeably to provide treatment and support. ACT staff members include prescribers, nurses, therapists, case managers, peer support specialists, employment specialists, and SUD specialists. These staff provide ongoing assessment and treatment planning, case management, psychotherapy, family support, employment services, crisis intervention, and community support to assist clients with living independently. Key components of ACT include a low client-to-staff ratio (no more than 10:1), services

provided in the community rather than the office, shared caseloads among team members, 24-hour staff availability for crisis intervention, comprehensive care/all service needs offered within the team, time unlimited services, and flexible, personalized care.

Assessment (i.e., biopsychosocial, level of care, functional, or strengths assessments) includes gathering information and engaging in a process with the individual that enables the provider to establish the presence or absence of a mental health and/or substance use disorder, determine the individual's readiness for change, identify strengths or barriers that may affect the processes of treatment and recovery, and engage the individual in the development of an appropriate treatment relationship. Appropriate assessments should be given during InReach visits by the transition coordinator/team. Team members providing assessments must have sufficient education, experience, and insight to develop a Person-Centered Recovery Transition Plan for everyone served, including collaboration with a multidisciplinary team of professionals. *[Note: Assessments may be provided as a stand-alone service through DIVERTS funding and need not be a component of Assertive Community Treatment (ACT)]*.

Community Residential Support (CRS): Provides supportive housing services such as skills training, assistance with activities of daily living, and assistance with community living skills to assist participants in living with maximum independence in community housing to increase community tenure, as identified in the participants' Person-Centered Recovery Plan. CRS ensures up to twenty-four (24) hours per day, seven (7) days per week, and 365 days a year of on-site support, as appropriate, depending upon individual resident needs.

Comprehensive Community Support Services (CCS): Services use various psychiatric rehabilitation techniques to improve daily living skills (hygiene, meal preparation, medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills, and developing and enhancing interpersonal skills. Activities are intended to ensure successful community living through skills training as identified in the participant's Person-Centered Recovery Plan. Skills training is designed to reduce functional disabilities and restore individuals to their best possible functional level.

Individual Placement and Support (IPS) Supported Employment: An evidence-based practice designed to assist individuals with SMI to obtain employment in a competitive environment using the support of their behavioral health treatment team, an employment specialist, and a benefits counselor. IPS IPS-supported employment services include person-centered job selection, job development and analysis, rapid job search and job acquisition with support, and long-term support and follow-up. The principles are planned and implemented through a partnership with the individual and the treatment team members, of which the Employment Specialist is a member, to assist the individual in achieving specific employment goals as defined by the Person-Centered Recovery Plan.

InReach provides engagement, education, and support by informing adults with SMI who are living in personal care homes, facilities, institutions, or are homeless about community-based mental health services and housing options. InReach activities in these settings include making and receiving referrals, completing an initial InReach visit with the individual, completing documentation, and referring the individual to the designated transition coordinator/team for assistance in moving into the community.

Peer Support: This is emotional support provided by persons who have lived experience of a behavioral health disorder to persons receiving treatment for a behavioral health disorder. Peer Support Services are structured, scheduled, and aligned with the goals identified in the client's treatment plan. Peer Support Services are non-clinical recovery-oriented activities conducted with individual clients or groups provided by a Peer Support Specialist who has been trained and certified under state regulations and who meets the ongoing requirements as defined in 908 KAR 2:220.

Person-Centered Planning: This is defined as a treatment/recovery plan developed collaboratively with an individual based on the individual's strengths. It identifies planned interventions, both billable and not, and the frequency and purpose of treatment interventions. This plan may be developed during multiple service planning sessions. Person-centered treatment and recovery plans stay with the individual after transition and need regular updating as circumstances change for that individual. Person-Centered Transition Plan: is a short-term plan directed by the recipient. It explicitly defines action steps, timelines, and responsible parties to ensure a smooth transition into community-based living and meets the terms of the TASA. This should be distinct from other person-centered planning. For additional information, refer to the section labeled Transition Plans in this manual.

Purchased Goods: Items not reimbursable through other sources that are individualized and utilized to reduce the need for assistance with personal care, enhance independence or safety in the home environment, and allow an individual to maintain a stable living environment in the community. Any good purchased shall be clearly linked to a demonstrated need.

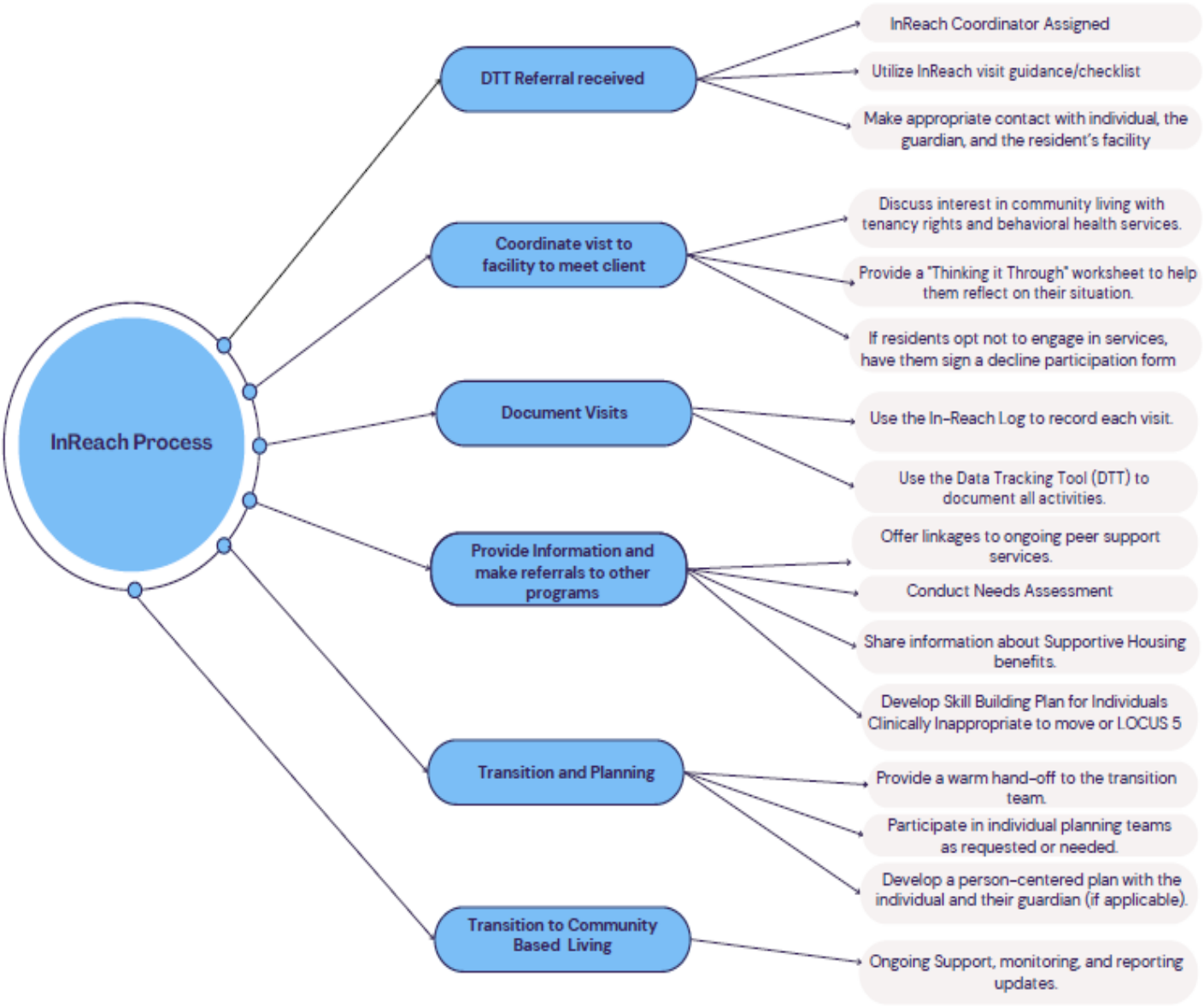
Service planning is assisting the individual in creating an individualized Person-Centered Treatment and Recovery Plan for services needed for maximum recovery from symptoms associated with a mental health disorder and/or co-occurring substance use disorder and restoration of the individual to the best possible functional level. Service planning may include an Advance Directive for Mental Health Treatment, a crisis plan, and/or a recovery plan. See the section in this manual labeled Making Referrals To Other Programs for more information.

Supportive Housing: These are activities necessary to assist adults with SMI in living with maximum independence in community-integrated housing to increase community tenure, as identified in the Person-Centered Recovery Plan. Skills training is designed to reduce functional disabilities and restore individuals to their best possible functional level. Areas addressed may include support to improve daily living skills, the self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills, and enhancing interpersonal skills. The Housing Specialist provides housing resource development, information dissemination, and assistance in securing housing for individuals with SMI.

Targeted Case Management: A set of services provided by a qualified professional (as defined in 908 KAR 2:260) to assist the targeted population in gaining needed medical, clinical, educational, social, and other recovery support services and includes: Facilitating and arranging services identified in the client's individual treatment or service plan; Assisting clients in accessing all needed services provided by a variety of agencies and other resources; Monitoring the client's progress through the full array of treatment and recovery services; Performing advocacy activities on behalf of the client; Providing case consultation; and Providing crisis assistance.

Consult with your agency's billing department for appropriate coding and funding streams for DIVERTS services.

INREACH VISITS



The purpose of InReach is to adequately inform individuals with SMI of all community-based options, including:

- Information about Supportive Housing
- Availability of rent subsidies
- An array of Community Mental Health Center services
- Availability of community supports
- Option to remain in the personal care home if they choose

InReach staff expectations:

- Make appropriate contacts with the individual, the guardian (if applicable), and the resident's facility before conducting InReach activities. See the InReach visit guidance/checklist in the InReach visit tools section for additional information.
- Coordinate a face-to-face meeting with residents and guardians, as applicable, to determine a resident's interest in integrated supported housing with tenancy rights and behavioral health services.
    - Document visits to PCHs using the In-Reach Log, which includes the date of each visit, length of visits to each facility, names of individuals spoken to regarding Housing Assistance and community-based supports, and the individual's response to discussions.
    - Establish a set day to visit each PCH in the hospital catchment area, with a minimum of one in-person visit per month.
    - Ensure residents are aware of the timing and providers of in-reach services.
- Provide information about Supportive Housing benefits.
- Provide linkages to ongoing peer support services as a step toward education and exposure to available housing options and supports.
- Facilitate and accompany individuals on visits to permanent housing.
- Offer opportunities to meet with other individuals with lived experience who are living, working, and receiving services in the community.
- Document all activities using the data tracking tool (DTT).
- Provide a warm hand-off to the transition team and participate in individual planning teams at the individual's request or as needed.
- Ensure InReach services are provided by or accompanied by a KY Certified Peer Support Specialist, if available, and they have adequate training in community supports and services.
- Offer to develop a person-centered plan with the individual and their guardian (if applicable) to build upon the skills they would need for a community transition from the personal care home or institution if they are deemed clinically inappropriate to move or LOCUS 5. Use the DTT transition plan as a guide to build the skill-building plan. Determine what areas the individual is clinically inappropriate to move in and develop the plan using the DTT transition plan.

COLLABORATING WITH PCH ADMINISTRATORS AND STAFF

Personal Care Homes are licensed by the Office of Inspector General (OIG). Personal Care Homes provide continuous supervision of residents, basic health and health-related services, personal care services, residential care services, and social and recreational activities (KRS 902 20:36). Additionally, Personal Care Homes are required to offer instruction in Activities of Daily Living (ADLS) AND Instrumental Activities of Daily Living (IADLs) to residents transitioning to independent living.

These skills training sessions should be integrated into the residents' daily lives, supporting person-centered planning principles. The Office of Inspector General primarily oversees PCHs in Kentucky. Still, many other state agencies are also involved with these facilities and their residents. The DBHDID manages or contracts to operate

three specialized mental health PCHs, the state psychiatric hospitals, and the community mental health centers that serve PCH residents. The department is also working with Medicaid to develop a plan to offer services to people with Severe Mental Illness (SMI) in the community.

Federal laws mandate that every state have an agency to represent and advocate for people with disabilities. Kentucky Protection and Advocacy, housed in the Justice and Public Safety Cabinet's Department of Public Advocacy, operates independently with federal funding. Agency staff investigate complaints, visit PCHs, educate PCH residents about their rights, and sometimes offer legal representation in negotiations and court. When the agency discovers possible regulatory deficiencies or harm to residents, it reports those situations to OIG and, if appropriate, to Adult Protective Services.

Collaboration is essential to achieve this work. It is critical to assist residents in developing their person-centered plans, but it is also necessary to ensure the client's needs and wishes are the priority. While it's important to interact and cooperate with PCH staff, the client is the primary driver of your efforts. Person-centered planning provides the means of determining the strengths of your client. Based on your assessment, person-centered planning will also help determine the skills the client needs to learn before they can live independently in the community. Person-centered planning will help the InReach coordinator determine the continued services and skills the client will need before they transition. The InReach coordinator may then refer the client to additional services such as therapy, peer support, budget management, and local transportation providers, ensuring they have the tools they need to live independently.

POSTERS AND CALENDAR POSTING

Regularly scheduled InReach visits should be posted on the activities calendar at each PCH. This should be done in collaboration with PCH administrators and their staff. InReach coordinators can also provide a flier to post on their community bulletin board. Your DBHDID liaison can provide posters to hang at each PCHs to encourage residents to consider transitioning to community living. Maintaining a consistent schedule of monthly visits to the PCH is crucial. It ensures ongoing support and engagement with residents, fosters trust and familiarity, and promptly identifies evolving needs or concerns. Consistent visits also build rapport between the visiting team and residents, enhancing the effectiveness of any interventions or support offered.

PREPARING FOR INREACH VISITS AND DTT REFERRAL FOLLOW-UPS

Residents in a personal care home (PCH) may be there for a variety of reasons. Research indicates that a change in living arrangements ranks among the top ten most stressful life events. Existing family dynamics compound this stress, the impact of the resident's diagnosis on their life, and the turnover of familiar faces and friends. The resident's response to their environment can vary significantly - some may be content in their current setting, while others may prefer to be elsewhere. The initial meeting with a resident is often *unpredictable*, with each visit presenting a unique set of circumstances. This variability can influence how effectively communication is established. Establishing a rapport with residents in PCHs may require multiple visits to build sufficient trust before productive interactions can occur. Several tools have been developed to facilitate communication. The InReach guidance checklist outlines considerations before, during, and after your visit. Additionally, a suggested script is provided to assist in establishing communication with residents. For residents who may not be ready to move or are undecided, a "Thinking it Through" worksheet is available to help them reflect on their situation. In cases where residents opt not to engage in services, they will be required to sign a decline participation form, as detailed in the Documenting Refused/Declined Services Protocol).

INREACH VISIT TOOLS

InReach Visit Checklist

(Pre-Visit)		(At Visit)		(Post-Visit)	
Task	**Done**	**Task**	**Done**	**Task**	**Done**
Call the resident at the PCH and introduce yourself and the CMHC. Ask resident when you can come and visit. At the end of the call, ask to speak to the PCH Administrator or person in charge. Agree on the date that you and the resident can meet at a time that is not disruptive to the resident's or facility's schedule. At the same time, get the guardian's (private or state) name, address and phone number.	☐	Introduce yourself to the PCH Administrator/Staff that you are there, give them your contact information.	☐	Gather any additional resources or information/items the individual requested and determine best way to deliver them to individual.	☐
Call the guardian and let them know of your plan to visit with the resident. Ask if they would like to participate and if you can send them information.	☐	Verify guardianship status of pre-named expressors Request a copy of guardianship order from the PCH Administrator.	☐	Schedule site visits to supported housing apartments, if needed to assist person in decision-making process.	☐
Determine the resident's communication needs and/or need for assistive technology, sign language interpreter, sign-language, etc.	☐	If private guardian, verify contact information (name/address/phone).	☐	Schedule site visits to settings where individuals with disabilities are living, working or receiving services in integrated settings if needed or requested to assist person in decision-making process.	☐
Send a letter to the resident confirming your visit (send the same letter to the guardian, PCH Administrator, Ky P& A contact and Ky Long Term Care Ombudsman) Draft letter is attached.	☐	Check financial status of pre-named expressors and name /address/phone of payee. Information from wards of state guardianship can be requested from fiscal branch.	☐	Follow up with Olmstead Regional Transition Committee and DMH Facilities Liaison discuss transition to community setting and identify known barriers.	☐
Obtain guardian's permission to gather resident's financial information (for benefits planning purposes)	☐	Meet with expressors individually and in-private. Ask resident if you can take notes. Document resident "direction". Repeat their answers back to them to confirm understanding	☐	Make referral on the individual's behalf to for other services needed and identify any known barriers for resident in referral documents.	☐
Before the visit: Gather information about Medicaid, State Supplement, services covered under KY State Plan for Medical Assistance, Waivers and State funded service array, community options, supported housing, etc.	☐	Give resident handout or business card with your contact information	☐		
		Make general observations of facility, note any immediate concerns.	☐		
.		If other residents request assistance to move out of the facility, take their names and contact information and make an InReach referral for them and schedule some time on the next visit	☐		

The InReach visit Checklist is available as a fillable form, if you need help accessing it contact your DMH liaison or you can double-click it on the page here to open it.

INREACH VISITS: SAMPLE SCRIPT

The following is a script that can be used to start the discussion with residents living in PCHs. Take time to pause between questions. Pick the next question based on how they respond. There is no need to ask all of these questions on one visit. Consider asking these questions over multiple visits or encounters with an individual before asking more in-depth questions. Be an active listener!

First Visit Sample Script

1. Introduction:

"Hi, I am [Your Name], an InReach Coordinator with [CMHC]. My job is to help people who want to live independently in their own apartment or house find the housing and support they need. Would you like to talk about moving into your own place?"

2. Initial Agreement:

"May we talk about that?"

3. Explaining Options:

"With the proper support, you can live in your own place, like a house or apartment (sometimes with another person). This is usually called 'living in the community" or "independent living."

4. Current Living Situation

- "What do you like about where you live now?"
- "What are some things you don't like about where you live now?"

5. Exploring Preferences:

- "What are some things that you might like about living in your own apartment?"
- "What are some things that make you nervous about living in your own apartment?"

Detailed Discussion and Support Information

6.

Day-to-Day Life:

"What does a good day look like to you?"

7.

Exploring Support and Choices:

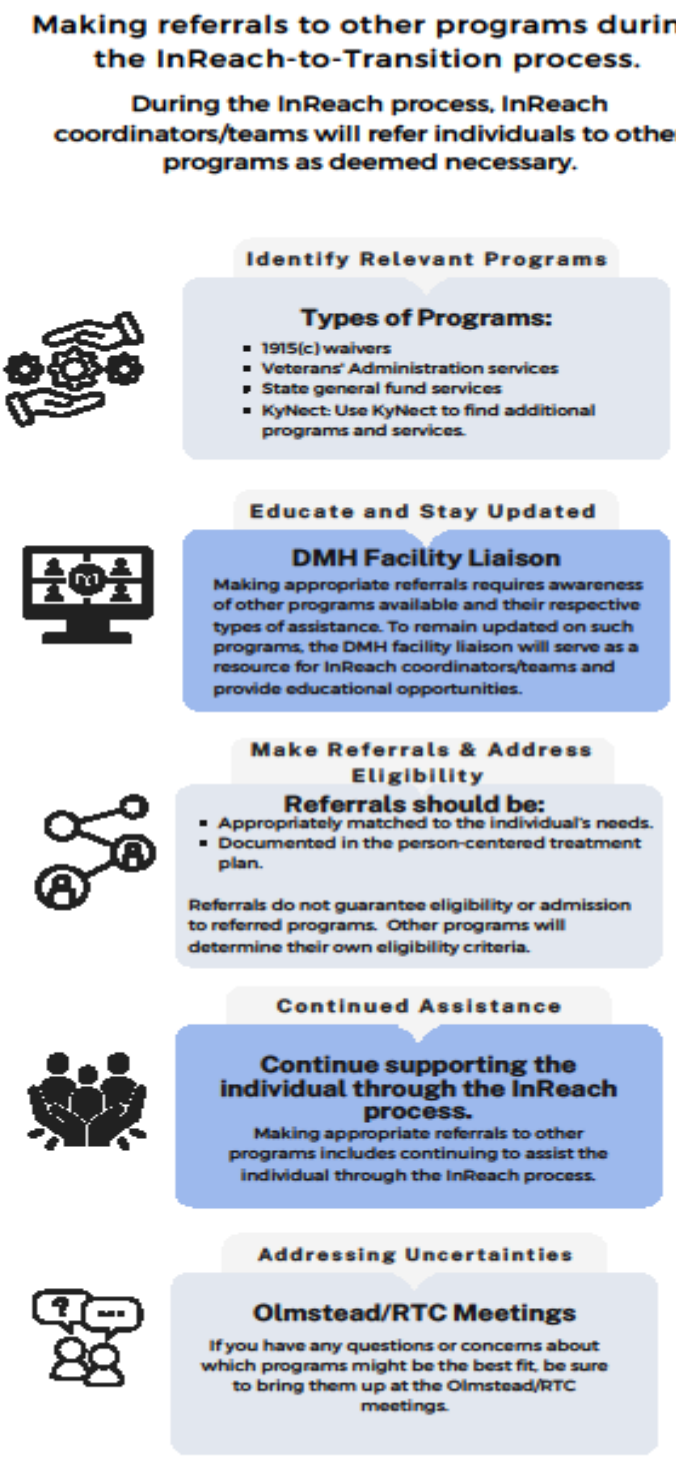
"We know that choosing where you live is a big choice and should be based on what feels right for you. Every place has its own set of challenges, but the decision of where to live is yours to make. Our goal is to ensure you feel confident and comfortable with your choice. We're here to support you throughout the process, whether that means assisting with job searches, helping you develop daily living skills, or providing any other support you may need. You have the freedom to choose any town or city in Kentucky that appeals to you. Right now, we want you to know the different options and the support/services you can receive. To help you decide, let's work on this, thinking it through together.

8.

Next Steps and Reassurance:

If you decide to stay here at [name of PCH], that's perfectly fine, and I will visit you again to discuss living in the community and check in to see if you have changed your mind. To help you decide, we've created a 'Thinking it Through' worksheet that you can keep if you're not ready to move or if you're still undecided. If you choose not to engage in any services at all, you can sign a decline form. Let's work through this together and make sure you have everything you need to make the best decision for yourself."

MAKING REFERRALS TO OTHER PROGRAMS DURING THE INREACH-TO-TRANSITION PROCESS



REPORTING REQUIREMENTS MONTHLY INREACH LOG & REGULARLY SCHEDULED VISITS

DBHDID is committed to ensuring that ongoing InReach occurs regularly and continuously for individuals in PCHs and cabinet-owned and operated psychiatric hospitals and individuals who choose to live independently in the community of their choice. DBHDID requires CMHC InReach Coordinators to document in-person and telehealth visits using the InReach log below. InReach Coordinators document each visit date, length of visit to each facility, names of individuals to whom they spoke regarding housing assistance and community-based behavioral supports, and the individual's response. To increase awareness by residents of services available, InReach providers are required to establish a set day to visit each PCH in their hospital catchment area, to include a minimum of one in-person visit per month *(See sample monthly InReach schedule)* to each PCH serving individuals who receive State Supplementation under 921 KAR 2:015, Section 13.

TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR BEHAVIORAL HEALTH, DEVELOPMENTAL AND INTELLECTUAL DISABILITIES

InReach Log

InReach Coordinator Name		**CMHC**	
InReach Coordinator Email			

Date	Resident Name	PCH Name	Visit Type	Time Spent
Topics Discussed				
Resident's Response				
Date	**Resident Name**	**PCH Name**	**Visit Type**	**Time Spent**
Topics Discussed				
Resident's Response				
Date	**Resident Name**	**PCH Name**	**Visit Type**	**Time Spent**
Topics Discussed				
Resident's Response				
Date	**Resident Name**	**PCH Name**	**Visit Type**	**Time Spent**
Topics Discussed				
Resident's Response				

InReach Log_Fillable.xlsx

Double-click the icon to open the InReach log.

The InReach log should be filled out during each visit to accurately record the residents' responses to topics discussed, which can be selected from a drop-down menu on the form. If you need help accessing the fillable form contact your DMH liaison or double-click the form to open. Those topics include but are not limited to housing, PCH care, medical concerns, guardianship, Medicaid, insurance, skill building, Locus evaluation, DTT Referral, transition plan, and mental health concerns. Multiple topics can be discussed during visits with the same residents. If more than one topic is selected, type in the topic discussed with the resident's response in that field.

EXAMPLE OF MONTHLY INREACH SCHEDULES

Region	Scheduled InReach Visits
1 – Four Rivers	Gather Suites - 1st & 3rd Friday monthly Fern Terrace - 1st & 3rd Friday monthly The Gardens - 1st & 3rd Friday monthly
2 - Pennyroyal	Better Senior Living – 1st and last week of each month Christian County Manor – 1st and last week of each month Madisonville Manor – 1st and last week of each month *Note: follow-ups are done via telehealth and phone calls in between visits.*
3 – River Valley	Davco - 1st & 3rd Monday monthly Lewisport Manor / the Oaks - 1st & 3rd Tuesday monthly Fern Terrace - 3rd Thursday monthly Henderson Manor – 2nd and 4th Monday monthly Davco and/or Lewisport Manor – 4th Thursday monthly depending on need
4 - LifeSkills	Cornerstone – 2nd and last Tuesday monthly Scottsville Manor – 2nd and last Tuesday monthly Hart County Manor – 2nd and last Tuesday monthly Harper's Home for the Aged – 2nd and last Tuesday of the month
5 - Communicare	CSH – Monday weekly
6 – Seven Counties	CSH – Tuesday & Thursday weekly Colonial House– Thursday weekly Colonial Hall – Thursday weekly
7 - NorthKey	Carrolton Manor – Wednesday weekly Valley Haven – Wednesday Weekly Frontgate – 4th Thursday monthly Falmouth Nursing Home – 4th Thursday monthly Regency Manor – 4th Thursday monthly
8 - Comprehend	River Outreach *(homeless shelter)* – 2nd Thursday monthly *Note: Additional visits are made as requested*
9/10 - Pathways	Genesis I & II - Last Tuesday monthly Frasure – Last Tuesday monthly
11 - Mountain	Venture Homes – Monday weekly Golden Years – Thursday weekly
12 – Kentucky River	ARH Hazard – 2nd Thursday monthly Haven *(homeless shelter)* – 2nd Thursday monthly *Note: Additional visits are done via telehealth or in person as requested.*
13 – Cumberland River	The Laurels – Tuesday & Wednesday weekly Generations – Wednesday weekly *ARH – when contacted by ARH staff*

14 - Adanta	Cumberland Manor McCreary County – 3rd Wednesday monthly Dishman Wayne County – 3rd Thursday monthly Crestview Pulaski County – 2nd Tuesday monthly
15 – New Vista	Waynesburg Manor – 1st Friday monthly Parkside – 2nd Friday monthly Shady Lawn – 2nd Friday monthly Rose Terrace – 3rd Friday monthly CKRC - 3rd Friday monthly ESH – 4th Friday monthly

PERSON-CENTERED PLANNING AND THE DTT TRANSITION PLANS

Person-centered planning is a facilitated, individual-directed, positive approach to planning and coordinating a person's services and supports based on individual aspirations, needs, preferences, and values. The goal of person-centered planning is to create a plan that will optimize the person's self-defined quality of life, choice, control, and self-determination. The process of developing a person-centered plan includes meaningful exploration and discovery of unique patient preferences, needs, and wants related to health and well-being, relationships, safety, communication, residence, technology, community, resources, and assistance. The person must be empowered to make informed choices that lead to developing, implementing, and maintaining a flexible service plan for paid and unpaid services and supports. The full report for Person-Centered Planning and Practice can be downloaded here, Person-Centered Report. Person-centered planning is the center of all service delivery; if you want more information about person-centered planning, contact your DBHDID liaison.

An initial person-centered transition service plan is to be developed within ninety (90) days of assignment to the transition coordinator/team for each individual. The person-centered transition service plan needs to be reviewed by a qualified professional who is clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner. Individualized DTT transition plans shall include psychiatric advance directives and/or crisis plans to incorporate such measures into the response to any behavioral health crisis. The DTT transition plan is a critical part of the overall person-centered planning for recovery and treatment for individuals transitioning to community living.

THE DBHDID DATA TRACKING TOOL

The DBHDID has managed referrals to the Settlement Agreement since the Interim Settlement Agreement. On 1/27/2015, DBHDID went live with an online referral management system (the Data Tracking Tool (DTT)), which included referrals made before and after that date. With the implementation of the Second Amended Settlement Agreement, the referral management system split the tool into two sections: one for ISA/ASA and the other for SASA. This was completed to accommodate the elements that differed between the Amended Settlement Agreement and the Second Amended Settlement Agreement. The referral management system was again divided into a third section to accommodate the Third Amended Settlement Agreement (TASA).

The DTT is a central point of data collection from Community Mental Health Centers (CMHCs) and reporting for the Settlement Agreement. Referrals are made to the tool by way of a completed web-based form that is available to the public at https:/dtt.dbhdid.ky.gov/ Upon receipt of the referral, notifications are sent to the Community Mental Health Center staff managing the referrals. Staff within these agencies collaborate and assist the referred person through the Inreach-to-Transition process.

Access to referrals are limited to InReach staff at CMHCs and appropriate DBHDID personnel. To get login credentials you must contact the system coordinator. Once you have been authorized access and have your login credentials you will be able to manage referrals at https://dtt.dbhdid.ky.gov/login/. Once logged in you will have access to all the referrals in the DTT. As with other electronic record management systems, there is proprietary information that must be coded when managing referrals. To help you navigate these DBHDID has included a reference manual under the reports tab at the top of the page on the right for easy access while managing referrals or you can download it here https://dtt.dbhdid.ky.gov/resources/data-tracking-tool-manual-july-2023.pdf.

InReach Coordinators will use the DTT to report all milestone activities. Please contact your DBHDID liaison to receive training or technical assistance with the data tracking tool and its operation.

STATE PSYCHIATRIC HOSPITAL DISCHARGE PROTOCOL

Individuals with serious mental illness who are discharged from inpatient psychiatric hospital settings shall be transitioned to permanent community-based housing, whenever possible, and not to settings such as personal care homes, boarding homes, homeless shelters, or other similar housing. Guided by the individual's preference, collaboration will occur with the individual, family members, guardians, service providers, and others to ensure that discharge planning begins upon admission to the facility and that the individual's informed choices are honored through the use of person-centered transition planning, and that every effort is made to develop a plan that maximizes the opportunity for community integration in housing and services.

A state psychiatric hospital may discharge an individual into settings other than permanent community-based housing, providing the following criteria are met:

- Discharge/transition planning is initiated at admission and developed through a Person-Centered process.
- LOCUS and other assessments are completed as references for the appropriate service array needed to ensure a successful community transition.
- Individuals and/or guardians are fully informed regarding options for community resources and services, as needed and requested, including a referral to and/or connection with the assigned Community Mental Health Center.
- Upon discharge, the hospital establishes a referral/case file within the TASA data tracking system. Referrals can be made at https://dtt.dbhdid.ky.gov/default.aspx.

TRANSFER BETWEEN REGIONS PROTOCOL

The following steps provide a systematic process of transferring service coordination services from one region to another for individuals associated with the Settlement Agreement.

1. Region A completes the InReach tool and LOCUS assessment.
2. Region A InReach Coordinator (IRC) contacts Region B InReach Coordinator (IRC) and discusses the case, confirming contact via e-mail with Region B and carbon copies to TASA Project Administrator
3. Region B IRC explores available options for housing, services, assistance, etc., and gives information to Region A IRC.
4. Region A IRC gives this information (including any regional brochures, printed material, etc.) to the individual and guardian (if the individual has a guardian).
5. If the individual still wants to move forward with the regional transfer after receiving the information. The two InReach Coordinators work together to meet the individual's goals, arrange dates of regional visits to meet staff, arrange apartment searches, arrange service coordination, transportation, etc.
6. Region A IRC's responsibility is to continue working with the individual, assisting them in securing the necessary documents required for the individual to obtain housing. Some required documents are a birth certificate, criminal background check, social security card, photo identification, and updated Verification of Income letter. Any supporting documentation, such as medical/psychiatric history, LOCUS score, and InReach referral/tool, should be forwarded to Region B IRC. Region A IRC will continue to check in with the individual/guardian, maintain the individual on their regional list, and ensure they are in the correct status on the ISA tool.

Psychosocial history, most recent physical exam/blood work, and medication list should also be forwarded to Region B IRC.

7. Any information that helped you form your opinion about the client's eligibility for ACT should also be forwarded to Region B IRC.
8. Most importantly, remember that ALL this has to occur within the 90-day transition period, so there is no time to waste.
9. Regions A & B provide monthly updates on progress at Regional Transition meetings. When the transfer date (move-in is imminent), Region A and B IRCs/RTCs contact their DBH liaison with the move-in date information.
10. The transition to Region B's Tracking tool occurs on the move date (the first night in the apartment). After this date, Region A will no longer be responsible for individuals, and the TASA Project Administrator will transfer them from Region A to B using the tracking tool.

Due to everyone's unique situation and each region's staffing availability, these arrangements should be made through coordination of the two regions on a case-by-case basis. When possible, transportation may be provided by the region, a family member, or a guardian.

MANAGING REFERRALS IN THE DBHDID DATA TRACKING TOOL DURING THE INREACH-TO-TRANSITION PROCESS PROTOCOL

The following strategies ensure a referral management system for individuals referred for services in the DTT concerning the Settlement Agreement.

1. The Cabinet for Health and Family Services, DBHDID, will maintain a referral management system to assist its providers in managing referrals of persons that meet the criteria for being served under the Third Amended Settlement Agreement (TASA). The tool created to manage referrals is called the Data Tracking Tool.

2. The DBHDID will maintain the Data Tracking Tool User's Manual.

3. CMHC InReach coordinators will manage referrals assigned to their respective CMHC. DBHDID staff serving as Regional Transition Committee Liaison (regional liaison) will provide technical assistance guidance.

4. The Data Tracking Tool will track elements related to the Third Amended Settlement Agreement (TASA) provisions. These include but are not limited to:

    a. Number of persons receiving housing assistance under the terms of the TASA;

    b. Progress status of milestones achieved in the InReach-to-transition process;

    c. Systemic barriers to transitioning individuals out of personal care homes and

    d. Systemic obstacles to post-transition, long-term success.

DOCUMENTING REFUSED/DECLINED PARTICIPATION PROTOCOL

At any time, individuals or their guardians may decline/refuse to participate in the InReach-to-Transition process while managing a Data Tracking Tool referral. Documentation of declined/refused participation is required for referrals made on or after October 1, 2018. Upon completion upload the Declined Participation form into the respective referral on the DBHDID Data Tracking Tool. If the individual has a guardian, the form should have signatures from both the individual and the guardian. The client should sign and date first, and then the guardian should sign and date afterward to acknowledge the client's desire to refuse services.

Procedure for Documenting that Someone Has Changed Their Mind and No Longer Refuses to Participate

During the management of a Data Tracking Tool referral, individuals or their guardians may change their minds at any time from refusing/declining participation in the InReach-to-Transition process. If the individual or guardian informs the CMHC staff member that they have changed their mind, the referral Transaction Code History is edited to reflect that decision. "Client no longer refuses services" and "guardian no longer refuses services" are applicable codes to use for referrals. The DBHDID Data Tracking Tool User's Manual will guide the user in entering transaction codes.

OLMSTEAD COMMITTEE/RTC MEETINGS

Olmstead and Regional Transition Committee

The Olmstead and Regional Transition Committee meets virtually monthly. Separate meetings are held for each of the four hospital catchment areas (ESH, WSH, CSH, ARH) to discuss specific consumer issues and develop transition plans and budgets for individuals who have been in care longer than 90 days. The Committee comprises hospital discharge planners, CMHC staff, DBHDID liaisons, MCOs, DPA, Guardianship, Ombudsman, and others deemed appropriate to address the individual's needs. It also provides an opportunity for the exchange of information and engagement in problem-solving to identify barriers that prevent individuals from successfully transitioning from institutional to integrated community settings, according to the terms of the Settlement Agreement. Any systemic issues/barriers identified are reported to the Cabinet Level Transition Committee as recommendations and/or requests for assistance. The State Hospital Director or Designee and DBHDID Hospital Liaison cohost the meeting.

During the meeting, InReach coordinators from each CMHC within their catchment areas give reports on the individuals with whom they are working to transition them from personal care homes or psychiatric hospitals, or who are at risk of institutionalization. They also share any barriers keeping individuals from transitioning and seek feedback from the committee for solutions. Accessibilities issues with PCH are discussed during these meetings by InReach Coordinators. Accessibility issues could include difficulty working with PCH staff, inability to locate the referral due to schedule conflicts, health & safety concerns, or any other barrier to providing services to the patient.

Olmstead Wraparound Committee

Funds from the state are allocated for Olmstead Wraparound expenses in each catchment area to support individuals living independently within their communities. A specific Community Mental Health Center (CMHC), geographically located in the same catchment area as the state hospital, manages the allocated Olmstead funds following the guidance provided by the Olmstead Wraparound Committee. These funds are used solely to meet the personalized needs of the consumers.

Each state or state-contracted psychiatric hospital convenes a committee to review cases and prioritize patients for the Olmstead program. Each committee includes a representative from the hospital, CMHCs in the region, Community Residential Support homes in the catchment area, and the Division of Mental Health.

All committee members provide input and vote on appropriate services and the allocation of funds. The Division of Mental Health votes only in the event of a tie.

The target group for funding is individuals who meet Olmstead criteria and have resided in a state psychiatric hospital for more than 90 days. Olmstead criteria include:

- Community treatment is appropriate;
- Identified persons are informed of options and do not oppose community treatment and
- Placement can be reasonably accommodated, considering the resources available to the state and others with mental disabilities.

Persons with priority for the program include individuals who meet Olmstead criteria and:

- Have resided in the hospital for over 90 days; or
- Have had repeat admissions to the hospital over one year and need wraparound services to remain in the community and
- Are served under the Settlement Agreement

The priority groups above may be expanded to include individuals in the Central Kentucky Recovery Center ready for community placement. If an individual in one of the above three groups has chosen Central Kentucky Recovery Center for community placement, placing another person will free up the needed placement slot.

Transition Plans (Note, this is not the same as the transition plan in the DTT)

- A transition plan and cost analysis are developed for each affected consumer.
- The transition plan is an extension of the hospital's discharge plan
- The consumer's preferences are emphasized.
- Community services needed are identified.
- Additional supports (peer support, for example) are also noted
- The transition plan also addresses efforts to provide informed choices regarding community living arrangements and choice of services.

Individual Budgets

Funds are designated for purchasing services and supports based on a person-centered plan. One plan may cost more; therefore, individual budgets must be prepared based on a menu of services. Typical services may include, but are not limited to, case management, residential support, supported employment, therapeutic rehabilitation, or medications. Expenditures may include one-time purchases such as rent or utility deposits, furniture, or clothing.

These funds may not be used to pay for services available to the consumer through an existing funding stream.

TYPICAL SERVICES PROVIDED BY OLMSTEAD WRAPAROUND FUNDS

1. Enhancement of daily living (e.g., electronics, music, craft items, clothing, fitness equipment, membership in a fitness club, etc.)
2. Mental health services (e.g., psychiatric, counseling, case management, community support services, therapeutic rehabilitation, peer support, IDD services, etc.)
3. Additional staff supports (e.g., outings, exercise, games, educational ventures, etc.)
4. Transportation
5. Purchasing prescription medication not otherwise covered

6. Purchasing animal companions
7. Self-esteem enhancement (e.g., haircuts, makeovers, hair styling, manicures, pedicures, etc.)
8. Meeting health needs not covered by Medicaid, Medicare, or other insurance (e.g., visual, dental, etc.)
9. Providing personal items (e.g., household items, room decor items, furniture, etc.)
10. Housing

These are examples of items and/or services that may be provided to Olmstead clients. However, this is an outside-the-box program. Anything promoting client success would be considered for implementation if the budget allows.

How to request Olmstead funding

- If items requested can be obtained through a purchase order, a purchase order request (AGENCY SPECIFIC) should be completed.
- If items requested cannot be obtained through a purchase order, a Request for Check or use of credit card (if acceptable by the fiscal agent by their agent) form should be completed. If you are still trying to decide which request you should submit, contact your DBHDID liaison.
- The request for Purchase Order or Request For Check should be signed by the agency staff requesting funding and submitted to the appropriate regional catchment area accountant to verify the Transition Plan and Cost Analysis availability of funds. The accountant will assign the tracking ID number to the request for payment and submit it to the program director at the fiduciary CMHC for approval. The Olmstead Funding Request Form, with client information, will be filed in the accountant's office because of confidentiality. No client name or social security number, only tracking ID number, will be listed on any Request For Check or Purchase Order.
- After the program director's approval, the funding request should be submitted to the CFO for financial approval and then forwarded to Accounts Payable for processing.

How to verify the Olmstead Funding request

- The Olmstead case manager submits a copy of the Transition Plan and Cost Analysis to the appropriate regional catchment area accountant. A Transition Plan and Cost Analysis are completed for each client, indicating the amount of the approved budget.
- Upon receipt of the funding request, the accountant will identify whether the client is eligible for funding and indicate the previously assigned tracking ID number on the request. No client name or social security number will be listed on any check or purchase order request; only tracking ID # numbers will be. The accountant will compare the request to the Cost Analysis to verify whether it is eligible for funding.

How Payment is Issued

- Upon receipt of the approved request, a check will be issued to the appropriate vendor, or a purchase order will be forwarded to the case manager. The Olmstead account line code is 9410. A client tracking ID# will be on each check or purchase order issued.

OLMSTEAD HOUSING INITIATIVE

The primary goal of the Olmstead Housing Initiative (OHI) is to meet the demand for housing for individuals who are currently in, or at risk of entering, institutions, such as psychiatric hospitals or personal care homes, or who have a history of frequent institutionalizations. This is in response to the Olmstead Supreme Court decision, which affirmed that the civil rights of individuals with disabilities include the right to receive care in the community as an alternative to long periods of institutionalization, mainly due to limited state funding for community alternatives. DBHDID implements the OHI program and other community support programs to ensure that individuals with serious mental illnesses who meet Olmstead criteria have viable transition plans that ensure community-based housing and services. (Additional information: https://www.ada.gov/olmstead/index.htm https://dbhdid.ky.gov/olmstead.)

Individuals eligible for OHI (Other Health Impairment) are 18 years of age or older and have a serious mental illness. They must meet the "Olmstead" definition, which means they have been hospitalized for longer than 90 days, are at risk of being institutionalized, or have a history of frequent hospitalization and limited success living in the community. Priority is given to individuals who are part of the Settlement Agreement between the Cabinet for Health and Family Services and Kentucky Protection and Advocacy. Assistance and resources available through the OHI program include Rental Assistance/Ongoing Rental Subsidy (often referred to as a voucher), housing deposits, utility deposits, household furnishings, moving expenses, pest eradication, and expenses interfering with transitioning (i.e., unpaid previous utility bills, first month's rent.)

Individual referrals will only be accepted from authorized sources of contracted DBHDID providers. The referrals must be made on the approved OHI referral form, and the referring agency is responsible for ensuring that all information is accurate. For additional information on how to make OHI referrals, contact your DBHDID liaison.

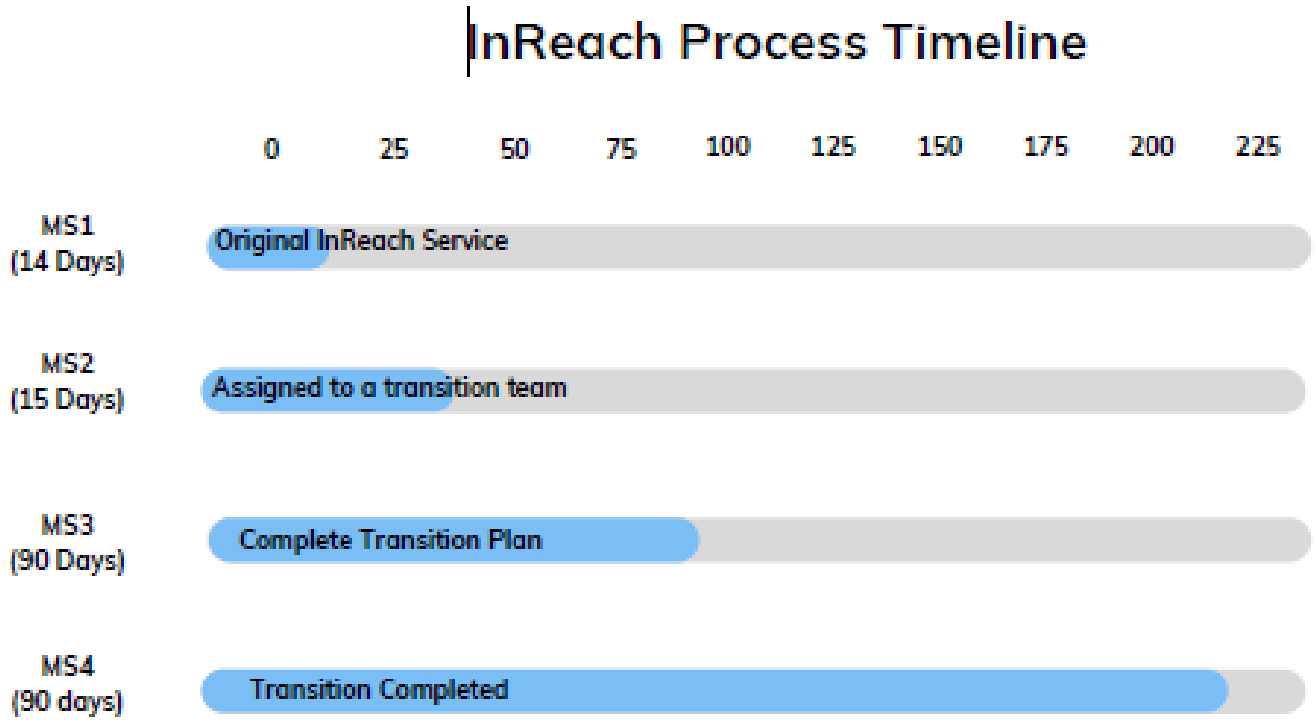
The Olmstead Housing Initiative is a 36-month bridge program that enables participants to lease permanent housing. Efforts toward long-term housing subsidy options should be a priority in services offered as part of OHI funding sypport. Participants who are still looking for permanent housing options after the 36-month timeframe may continue Olmstead Housing assistance upon approval of DBHDID until permanent housing can be secured. DBHDID requires contracted providers to maintain ongoing tenancy support services for individuals who receive ongoing rental subsidies until the individual bridges to permanent supportive housing or some other form of ongoing rental subsidy.

APPENDIX A - SETTLEMENT AGREEMENT HISTORY

The Cabinet for Health and Family Services has been under a Settlement Agreement since August 15, 2013, when the Interim Settlement Agreement was executed. Additional agreements followed. The Amended Settlement Agreement (ASA) was executed on October 19, 2015, followed by the Second Amended Settlement Agreement (SASA) executed on October 22, 2018. The Third Amended Settlement Agreement (TASA) was executed on July 1, 2023. The impetus of the agreements was to improve and monitor access to services for individuals with serious mental illness (SMI) residing in or at risk of entry into a personal care home (PCH). It is the Department for Behavioral Health, Developmental & Intellectual Disorders' (DBHDID) goal to ensure that these eligible individuals receive services provided in the most integrated setting appropriate to meet their needs under Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12131, et seq., as interpreted by the United States Supreme Court in Olmstead v. L.C., 527 U.S. 581 (1999), and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a). Accordingly, through the ISA, ASA, and SASA, the Parties intended that the steps to achieve the goal of community integration and self-determination would be undertaken.

At the time of the ISA, ASA, SASA, and TASA, Kentucky Protection & Advocacy (P&A), on behalf of individuals with SMI residing in or at risk of entry into a PCH who receive or could receive State Supplementation, was prepared to file a federal lawsuit, asking the Court to certify a class of approximately 2,300 individuals to ensure compliance with the ADA, Olmstead, and the Rehabilitation Act. Those claims remain viable, and the Cabinet acknowledges that PCHs are institutions covered by the ADA, Olmstead, and the Rehabilitation Act.

A set of milestone markers have been created to aid in the community transition for individuals who want to gain independent living. These milestones are tracked within the Data Tracking Tool.



APPENDIX B – SETTLEMENT AGREEMENT MILESTONES

Activity and accomplishment toward Settlement Agreement milestones are recorded in the "Transaction Code History" section of a referral within the Data Tracking Tool. Specifically, the milestones are:

- Original InReach Service, (MS1)
- Assigned to a Transition Team, (MS2)
- Completion of a Transition Plan, and (MS3)
- Transition Completed. (MS4)

Original InReach Service

Per the Agreement, this will be accomplished and recorded within 14 days of the referral date. This expectation aligns with the performance indicator in the BHDID-CMHC contract section "Direct Intervention – Vital Early Responsive Treatment System (DIVERTS)."

InReach involves locating the person for whom the referral is made, arranging a time to talk with the person and/or their guardian, and asking them if they want to participate in the InReach-to-Transition process.

Assign to a Transition Team

Assignment of a Transition Team to the individual's case will occur within 15 days of the Original InReach service. This milestone indicates that the agency has achieved the original InReach service and has assigned a staff member or team to work with the person during the remainder of the process.

Completion of a Transition Plan

Per the Settlement Agreement, a transition plan must be completed for all referrals after they are assigned to a transition team and before the person physically moves (transition completed). A sample of the transition plan is attached in Appendix C. Transition plans are completed in the referral processing section of the Data Tracking Tool for each referral.

Transition Completed and Transition Completed without CMHC Assistance

This milestone follows the completion of the transition plan. "Transition Completed" or "Transition Completed without CMHC Assistance" is recorded after the person physically moves. In the case of a hospital discharge diverted from personal care home living, it is the date of the discharge to housing in the community. These two transaction codes do not apply to temporary or interim housing and should only reflect when the person moves into permanent housing.

APPENDIX C – TRANSITION PLAN

Person-Centered Transition Plan

Completed after the person has been "Assigned a Transition Team" and before "Transition

ANTICIPATED DATE OF TRANSITION:

NAME: _____
ID#: _____

Region: _____

YELLOW – Support/Services Required

PERSONAL HYGIENE	**Supports/Services Needed**	**Responsible Party**	**Timeframe**
☐ I put on clean clothes every day without reminders or assistance.			
☐ I shower, bathe, and brush my teeth every day without assistance.			
☐ I need to be reminded or be assisted to complete daily personal grooming (i.e., showering, dressing, brushing teeth)			
FOOD PREPARATION	**Supports/Services Needed**	**Responsible Party**	**Timeframe**
☐ I buy food, store food, and prepare meals without assistance.			

☐ I can shop for groceries without assistance.			
☐ I need assistance with shopping, storing, and preparing meals.			
☐ I need assistance in learning household chores.			
TRANSPORTATION	**Supports/Services Needed**	**Responsible Party**	**Timeframe**

☐ I can drive or use public (bus, taxi) transportation without assistance.			
☐ I know how to be safe in using crosswalks and following pedestrian rules when I am walking on my own without assistance.			
☐ I need assistance in learning about pedestrian rules and how to arrange for transportation, especially in a new area.			
MONEY MANAGEMENT	**Supports/Services**	**Responsible Party**	**Timeframe**

	Needed		
☐ I know how to pay my bills on time and keep my money safe.			
☐ I need assistance with getting benefits and using banking services.			
☐ I need a protective payee to handle my money and pay my bills.			
HOME SAFETY	**Supports/Services Needed**	**Responsible Party**	**Timeframe**
☐ I know how to be safe in my home without assistance.			
☐ I never open the door without knowing who is there. I keep my door locked and know how to call 911 without assistance.			
☐ I know how to safely use appliances (stove, microwave, heater, washer/dryer, etc.). without assistance.			

☐ I can safely smoke cigarettes, have smoke alarms, and know what to do if a fire occurs.			
☐ I would like to learn how to keep safe in my living environment.			
MEDICATION USE	**Supports/Services Needed**	**Person Responsible**	**Timeframe**
☐ I can take all my medications at the correct time and dosage.			
☐ I need assistance with setting up my medications in advance.			
☐ I need to be reminded daily to take my medication.			
☐ I frequently get medication mixed up and take more or less than is needed.			
PHYSICAL HEALTH	**Supports/Services Needed**	**Person Responsible**	**Timeframe**
☐ I have the following physical health conditions:			

Please list:			
☐			
☐			
☐			
☐			
☐ I can take care of all of my physical health needs.			
☐ I need assistance with the maintenance of some or all of my physical health conditions.			
☐ I need assistance in finding a physician, dentist, or specialist.			
☐ I need assistance in scheduling and getting to and from appointments.			
☐ I need assistance in securing Medicaid or other health insurance benefits.			

SOCIAL	Supports/Services Needed	Person Responsible	Timeframe
☐ I feel pretty good about myself, am happy most of the time and like to keep active.			
☐ I need assistance in attending events and finding things that I like to do, in my community.			
☐ I need assistance in getting supplies/materials for activities I can do in my home.			
☐ I need assistance in finding and attending a church; which may include transportation.			

Crisis Plan	Has a crisis plan been completed? ○ Yes ○ No/Unknown
Advanced Directive	Does the individual have an advanced directive? ○ Yes ○ No

APPENDIX D FORM USED TO DECLINE PARTICIPATION

An agreement has been signed between Kentucky's Cabinet for Health and Family Services and Protection & Advocacy (P&A). Within the terms of this agreement, the Cabinet agrees to support the voluntary transition of individuals with Serious Mental Illness (SMI) from living in personal care homes to integrated community-based housing. Community-based housing includes owning one's home/apartment, renting a home/apartment with a lease, or living with a parent or guardian with a lease. The agreement is not an official lawsuit, nor does it involve any federal agencies, such as the U.S. Department of Justice. The Cabinet established a Kentucky Administrative Regulation to assure the continuation of efforts defined within the Agreement - 908 KAR 2:065.

This program has been explained to me, and I understand _____ (initial) _____ (date) Available Services and Supports.

Kentucky's Cabinet for Health and Family Services is partnering with the Community Mental Health Centers (CMHCs) to reach out and support adults with Serious Mental Illness who want to live in community-based housing instead of a personal care home. Other services and supports may be available from the Community Mental Health Center to support persons before and after moving out of a personal care home. Examples of such services include but are not limited to Assertive Community Treatment, Supported Employment, Supportive Housing, and Peer Support; services are dependent upon eligibility and insurance approval.

These services and supports have been explained to me and I understand _____ (initial) _____ (date).

How to Participate

Individuals or their guardians may express their desire to move to community-based housing by telling a CMHC staff member, a long-term care Ombudsman, their guardian, and other professionals, or they can refer themselves online at https://dbhdid.ky.gov/ISA or by calling 1-800-374-9146 (ext 8.). This also applies to any individual or guardian who initially declines participation and later wants to participate after changing their mind.

This process has been explained to me, and I understand _____ (initial) _____ (date).

How to Decline Participation

Individuals who do not want to be asked again about transitioning from a personal care home into community-based housing can express this by signing on the line below.

I understand that I may decline participation; my signature below means I decline. I do not want to be approached again about this opportunity.

_____ _____

My Signature Date

_____

My Printed Name

_____

Print Name of Personal Care Home

_____ _____

Guardian's Signature Date

_____ _____

Guardian's Printed Name Type of Guardian (state, private, conservator, limited, other)

APPENDIX E THINKING IT THROUGH WORKSHEET

Thinking it Through Worksheet

Use this worksheet to help residents is considering living in the community. We have prefilled the form where the answers were already known.

	If you stay in the PCH?	If you decide to move	+/-
My Benefits			
Will I receive my Medical Benefits?	Yes	Yes	
Will I receive my State Supplement	Yes – it goes to PCH	Yes, you will use it to pay for services	
Will I receive my SSI or SSDI check	Yes – It goes to PCH	Yes	
My Money			
After bills are paid, do I have spending money?	$60 a month		
How do I get my spending money?	From PCH Owner		
Who pays my bills including rent?	PCH		
What will my payee status be?	Same	Same	
My Home			
Do I live near family and friends?			
Do I have a choice about where I live?			
Do I have my own bedroom?			
Do I choose whether or not I have a roommate?			
Are the things I need to feel safe available to me?			
Am I allowed to have guests anytime I want to?	Yes		
How do I make sure I have food to eat?			
My Medical/Mental Health Support			
Can I keep my current doctor?	PCH decided	If same area	
Can I switch doctors?	Yes	Yes	
Can I keep my pharmacy?	Yes	Yes	
Do I understand the treatment services I'm eligible to receive?			
What happens if I have a medical or mental health emergency?	PCH calls	I will call Crisis Line, ACT team, 911, 988	
How do I get my medications?	PCH Staff	I will with help from ACT team or other supports	
Who will make sure I take my medications?	PCH Staff	I will with help from ACT team or supports	
My Community			
How do I get around to do the things I enjoy?	Walk		
Who can assist me in getting a job?	Me/guardian	Supported Employment	
What type of social opportunities do I have?	PCH		
How often will I see my friends?			

My In-Reach Specialist's Name and Phone number _____

APPENDIX F TRANSITION PLAN FOR OLMSTEAD WRAPAROUND FUNDS

TRANSITION PLAN FOR DISCHARGE

DATE _____

Name of Patient _____

Social Security Number: _____

Patient has Guardian or Representative: Yes ☐ No ☐
If yes, please provide name: _____

Patient's preference for community placement:
_____

Treatment team determines discharge is appropriate: Yes ☐ No ☐

Patient consents to discharge: Yes ☐ No ☐

Placement can reasonably be Accommodated: Yes ☐ No ☐

{Examples of Needs to be addressed below: Medical, Medication, Substance Abuse, Psychiatric/Therapeutic (e.g. counseling, social support, case management), Daily Living Skills (e.g. ADLs, skills training), Community Habilitation, Employment, Financial, Housing, Supervision, Transportation, Legal}

NEEDS	SERVICE	FREQUENCY	SERVICE Available Yes	SERVICE Available No	PERSON or AGENCY RESPONSIBLE
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

(continued on next page)

COMMENTS:

_____

Signature of Treatment Team Member

_____
Date

Signature of Patient or Legal Guardian/Representative

_____
Date

Signature of Transition Team Members _____
Date

Continuation page

Patient Name ______

NEEDS	SERVICE	FREQUENCY	SERVICE Available Yes	No	PERSON or AGENCY RESPONSIBLE
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
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			☐	☐	

REVIEWED:

Signature of Reviewer	Date	Signature of Reviewer	Date
Signature of Reviewer	Date	Signature of Reviewer	Date
Signature of Reviewer	Date	Signature of Reviewer	Date
Signature of Reviewer	Date	Signature of Reviewer	Date
Signature of Reviewer	Date	Signature of Reviewer	Date
Signature of Reviewer	Date	Signature of Reviewer	Date

APPENDIX G BUDGET FOR OLMSTEAD WRAPAROUND FUNDS

Olmstead Wraparound Expense Reimbursement Form

These funds cannot be used to pay for services that are available through an existing funding stream.

Region:

Patient Name:

Patient Social Security #:

Month/Year:

Service	Budgeted Total Cost	Monthly Cost	Year to Date Cost
For all line items over $100.00 explain the breakdown of cost on the bottom or attach supporting documentation.			
Total			
Prepared by:		**Date:**	

This section is completed by the Olmstead Committee Only.

☐ Approved by Committee ☐ Denied by Committee ☐ More Information is needed from Requestor

Kentucky Olmstead Housing Initiative
Individual Referral Form

1. Individual's name: Race: Gender: Ethnicity:
2. Date of birth: Age:
3. Olmstead eligibility (check all that apply): Serious Mental Illness (SMI): ☐
   Plus one or more of the following:
   a. In a Personal Care Home (PCH): ☐
   PCH Name: Length of Stay:
   b. In an State Psychiatric Hospital (or other institution) over 90 days ☐
   Institution Name: Length of Stay:
   c. Multiple psychiatric hospitalizations (or institutionalizations) ☐
   Institution Name: Length of Stay:
   Institution Name: Length of Stay:
   Institution Name: Length of Stay:
   d. At risk of institutionalization (If checked, submit At-risk form with referral) ☐
4. Is this person served under the Settlement Agreement? (check if yes): ☐
   a. Add Data Tracking Tool Number
5. Assistance needed (Please check all required)
   a. ☐ On-going Rental Subsidy
   b. ☐ Security and Utility Deposits
   c. ☐ Basic Furnishings/Household items
   d. ☐ Moving expenses
   e. ☐ 1st month's rent
   f. ☐ Interim rental assistance

   Reimbursements are limited to $1,000 for furnishings.

   Interim rent is in addition to the $1,000 and covers up to 3 months of center/agency owned or rented property used to house an individual until suitable housing can be found.
6. Service Provider (CMHC, other service providers):
7. Referral source:
   a. Name
   b. Phone
   c. Email
8. Other assistance needed or additional information:
9. Date:

Send completed form to:
Housing/Homelessness Services Program Administrator
Division of Mental Health
275 E. Main St., 4W-G
Frankfort, KY 40621
dennis.hall@ky.gov

TEAM KENTUCKY

Rev. 7/1/2024

Kentucky Olmstead Housing Initiative

At-risk of Institutionalization Form

Individuals Name:

Date of Birth:

An individual is determined to be at risk of admission to a PCH if the following criteria are met:

1. Adult with SMI
   Diagnosis: Date of Diagnosis:
   AND
2. Impairment in at least one major area of living - such as inability to care for or support self, communicate, or make and maintain interpersonal relationships
   Impairment area:
   AND
3. Requires services that prevent institutionalization – such as multiple mental health treatment services per month, Assertive Community Treatment, Intensive Case Management
   Services Received: How Often:
   Services Received: How Often:
   AND

---

4. Imminent institutionalization – plans or process in place for placement into a PCH (or other long-term care)
   Name of Facility: Contact at Facility:
   OR
4. One or more of the following:
   a. Long-term (≥90 days) inpatient psychiatric hospital stay within the last 60 days
      Hospital: Admission Date: Discharge Date:
   b. History of 2 or more inpatient psychiatric hospital admissions within the last 12 months
      Hospital: Admission Date: Discharge Date:
      Hospital: Admission Date: Discharge Date:
   c. History of multiple housing situation loss due to SMI-related symptoms/behaviors – such as evictions, inability to meet lease agreement terms, inability to retain housing controlled by family/friend/other.
      Dates of housing situations:
      Supporting documentation attached:

AND

5. Existence of a current diversion/transition plan (updated in the last 12 months)
   Plan Initialization Date:
   Supporting Documentation Attached:

TEAM KENTUCKY

Rev. 8/30/2023