Harvey-Marion County CDDO

Supporting increased independence, integration, inclusion, and productivity in individual homes and communities.

What to Expect from Your Targeted Case Manager (TCM)

Targeted Case Management (TCM) services assist the person and their support team to identify, select, obtain, coordinate, and use both paid services, and natural supports to achieve their preferred lifestyle. The case manager services as an advocate and the coordinator of services that are needed.

The responsibilities of the TCM include the following:

1. **Assessment –** The formal or informal process of evaluating a person's needs or preferences, which can assist with determining the resources available to them. Examples of this type of service are the BASIS (Basic Assessment and Services Information System) and the MFEI, and the Needs Assessment.
2. **Support Planning –** building upon the assessment information to assist people in meeting their needs or achieving their preferred lifestyle. This includes developing a person-centered support plan (PCSP), which is like a story about a person on what has happened in their past, where they are right now, and what they want to do in the future. Support Planning also includes such things as working with the person and their support team to develop positive behavior support plans and to identify and work toward replacing negative with alternative, positive behaviors if this is needed. Other paperwork completed in support planning also includes such things as a Plan of Care, documentation to DCF, and a Supportive Home Care Schedule as applicable.
3. **Support Coordination –** arranging for supports that are outlined in the person-centered support plan (PCSP) or developing natural or other community supports that can help the person to achieve what they want in their future. This includes advocating for the person to gain access to needed services or seeking modification of the current system to meet the person's needs.
4. **Monitoring and Follow-Up –** ensuring that supports and services outlined in the person-centered support plan are implemented correctly and are addressing the needs of the person.
5. **Transition and Portability –** planning and arranging for services when moving between any of the following: from school to the adult world, from an institution to the community, from one setting to another, or from one service provider to another.

How often will the TCM have contact with me?
While KDADS does not mandate a specific contact frequency, each agency typically establishes its own guidelines. The final decision, however, should rest with the individual and/or their parent or guardian, who should determine the ideal contact schedule with their case manager.

How are TCM services paid for?
For those with Kansas Medicaid, the cost of this service is billed to the Kansas Medicaid Assistance Program. For all other individuals, a sliding fee scale determines the cost. Many Community Developmental Disability Organizations have budget funds allocated to cover this expense, either fully or in part. The Harvey-Marion County TCM agency offers non-KanCare Targeted Case Management (TCM) at no cost. However, individuals are encouraged to choose a TCM provider that best suits their needs, understanding they will be responsible for any costs incurred with an outside agency.

How do I change case managers if I wish to do so?
If you have a concern regarding your case manager and/or would like to change case managers, this can be done through the same service provider by requesting that the change occur. If this is not an option that you would want to choose, you can also contact the CDDO in your area and request a change of case management providers. The CDDO will share with you the TCM service provider options available and will send you the required paperwork to make the change.

What if I do not want a case manager?
You do have the choice not to have a case manager. However, if the person and/or their guardian chooses not to have a case manager, the responsibility of coordinating the needed supports will remain with the person and/or their guardian. All planning, support coordination, and accessing of services will be left to the person and/or their guardian.

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What A Case Manager Needs to Know and Participate In:

To be effective as an advocate and in assistance with proper planning, the Case Manager needs to be informed of things as they change, and of some specific meetings that take place in a person's life. One of the goals of a case manager is to promote teamwork with the focus on the person who represents. To do this, the case manager will need to know and be included in a variety of information and any changes that are taking place for the person. The key to this is open communication and teamwork.

The case manager will need to be aware of and be invited to specific planning meetings for children and youth so that proper planning and teamwork may take place. Children who are on the SED Waiver have **Wrap-Around Meetings** that take place on a consistent basis and the case manager should be kept aware of when these are scheduled and be invited to attend these meetings. The goal of this is to assist the case manager in learning what is and is not important to the child/youth and their team, to know what future goals are in place, and to be able to assist in the transition from the SED Waiver to the DD Waiver in as seamless manner as possible when this is needed.

Another consistently held meeting for children and youth is an **Individual Education Plan (IEP)**. The case manager needs communication on when these meetings will be held and should be invited to attend as well. This also assists the case manager with learning about the child/youth and what direction that they are following, so that transitioning services may be more coherent to the future goals that he child/youth and their team has mapped out. At the age of 14 a youth is to begin transition planning within their IEP, as a plan on what they will do in their adult life. The State of Kansas mandates that the case manager takes an active role in this transition planning. Often the school system will cite that it is the parents' responsibility to make sure that the case manager is aware of and invited to these meetings. However, this can simply be that they are included on the list of invitations/notifications for the IEP meeting at the time that it has been scheduled. The parent and/or youth can simply follow up with the person scheduling the IEP to make sure that the contact information is known for the case manager and that the case manager is included in the notification of the meeting scheduled. An additional planning meeting(s) that a case manager should be aware of and invited to would also include **employment planning**. This includes such things as Vocational Rehabilitation Services, Project Search, or other Employment First meetings that are designed to assist the youth/adult in preparing for and entering the job market. The case manager can assist with this planning and will also need to include any of this information into plans prepared by them per regulations from the State of Kansas. The case manager may also be able to coordinate or assist with some things that may be needed for this to be most successful for the youth/adult.

This could include assisting with completion of the initial application to such programs, assistance in coordinating transportation for employment, and application for assistance if specific adaptive equipment or work-related expenses are required that the person cannot afford. The case manager can be an active member of the person's team with open communication with these services to promote greater success for the youth/adult.

In addition to being included in the different meetings that take place for children/youth/ adults, the case manager must also be provided with specific information that is designed to assist the person with the most up-to-date information in plans for services, assistance with the BASIS Assessment process, and promote teamwork. These things include: **Functional Assessment Behavior Tracking Sheets** that the case manager must provide to the BASIS Specialist each year; information about any **health-related changes** or a **change in diagnosis** that may take place; information about the person being **hospitalized** or having **surgery** take place; any **changes in medications** as the case manager is to include this information into the person's plan; any placement into a **PRTF**, **foster care**, admission into a **mental health hospital** or any **legal involvement** that the person may have; if the person moves or changes phone numbers the case manager will need to be provided the **correct address and phone number**; and if a situation arises that would require **crisis placement**, **funding for staff supports**, or the need of **adaptive or health-related equipment.**

Include your case manager in the following meetings and provide them with the following information to promote the greatest success, teamwork, advocacy, and promote a smooth flow for transition planning:

Wrap-Around Meetings
PRTF placement
Individual Education Plans (IEP)
Health-related changes
Legal Involvement
Hospitalizations or Surgeries
Diagnosis changes
Mental Health Hospitalizations
Medication changes
Need for Staff Funding
Foster Care Placement
Need for Adaptive Equipment
Vocational Rehabilitation & other work training programs
Any other communication to express your concerns, needs, or to have your questions answered

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