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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