



**DEPARTMENT OF HUMAN SERVICES AND OMBUDSMAN OFFICE FOR THE  
INSTITUTIONALIZED ELDERLY**

**FEDERAL INITIATIVE: MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION  
PROJECT**

**NEW JERSEY'S MFP PROGRAM: "I CHOOSE HOME NEW JERSEY"**

**EFFECTIVE DATE: July 1, 2014**

**DATE ISSUED: July 1, 2014**

- I. TITLE: Roles and Responsibilities for Effective Discharge**
- II. PURPOSE: Ensure that services and supports identified in the Transition Plan are arranged and coordinated prior to the individual's departure from the Nursing Facility (NF).**
- III. SCOPE: All Nursing Facility residents transitioning to community living that meet the MFP eligibility criteria.**
- IV. POLICIES:**
  - 1. Nursing Facility Discharge Planner:**
    - Assures that the discharge is planned, coordinated and executed;

- Assures that tasks assigned to IDT members are completed;
  - Notifies the MFP Liaison/Community Choice Counselor (CCC) from the Office of Community Choice Options (OCCO) and the Managed Care Organization (MCO) Care Manager (CM) of the participant's actual date of discharge, or if changed, the new date of discharge and the reasons for the delay;
  - Assures that the Transition Plan is modified to incorporate changes since the initial IDT meeting;
  - Returns any Personal Needs Allowance (PNA) to the participant;
  - Ensures that the Zero PA-3L(PR-1) is completed so that the participant will have his or her last month's income returned as part of the Month-of-Discharge Exemption;
  - Arrange for Medicare services post NF.
2. **OCCO MFP Liaison/Community Choice Counselor:**
- Contacts the MFP participant within 48 hours to verify that services have been delivered, and that he or she is adjusting to the community;
  - Assures all MFP paperwork (MFP 75, Quality of Life Baseline survey and signed consent form) is completed, signed and submitted to the MFP Associate Project Director/Designee in a timely manner.
3. **OCCO MFP Associate Project Director:**
- Upon receipt of the MFP Enrollment Packet, reviews the Packet for accuracy and completeness and assures the resident has met the MFP eligibility criteria by initialing the MFP 75;
  - Sends/delivers the MFP Enrollment Packet to the MFP Project Director by the 15<sup>th</sup> of each month (i.e. for residents transitioned in May, the Enrollment Packets should be received by June 15<sup>th</sup>).
4. **MCO Care Manager:**
- Faxes the MFP 75 to the appropriate OCCO Regional Office within 24 hours of discharge;
  - Within 5 days of discharge, makes initial contact with the participant;
  - Within 10 days makes a face to face visit:
    - To affirm that the services and supports identified in the Transition Plan are appropriate;
    - Incorporates Transition Plan and any changes to the Plan of Care (POC);
    - Finalizes the POC and obtains signatures of the participant/designee, Care Manager, and Care Manager's supervisor;
  - The MCO Care Manager becomes the primary Care Manager for the implementation of the Plan of Care for waiver services. The MCO Care Manager coordinates services between State Plan and Waiver services.