



STATE OF TENNESSEE  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
DIVISION OF MENTAL RETARDATION SERVICES  
ANDREW JACKSON BUILDING, 15TH FLOOR  
500 DEADERICK STREET  
NASHVILLE, TN 37243

**TITLE:** DMRS Central Office Intake Review Committee Policy

**POLICY #:** P – 007 – A

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- A. PURPOSE:** The purpose is to describe the policy for submitting requests to begin or continue the waiver enrollment process to the DMRS Central Office Intake Review Committee.
- B. APPLICABILITY:** This policy applies to any request for a person to begin or continue the enrollment process for admission into a Medicaid Home and Community Based Services waiver.
- C. DEFINITIONS**
1. “**HCBS waiver**” or “**waiver**” means a Home and Community Based Services waiver for persons with mental retardation that includes the following;
    - a. Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled (#0128.90.R2A.02) and any amendments thereto;
    - b. Home and Community Based Services Waiver for Persons with Mental Retardation (#0357.90.02) and any amendments thereto; and
    - c. Self-Determination Waiver Program (#0427.02) and any amendments thereto.
- D. DESCRIPTION OF POLICY**
1. The DMRS Central Office Intake Review Committee will review information from the DMRS Regional Offices about individuals who have the greatest need for waiver services and will determine who may be approved to begin or continue the enrollment process based on the availability of funding.
  2. Each Regional Director (or designee) shall complete the following steps at least 2 days prior to the regular monthly meetings of the DMRS Intake Review Committee:
    - a. Submit a list of the names of individuals having the greatest service needs;
    - b. Prioritize each individual on the list into one of 3 categories representing the degree of need – very high, high, and moderate;
    - c. Provide a brief description of the situation and give details to justify why there is an immediate need for services;

- d. Submit requests to the Assistant Commissioner of Community Services, with a copy to the Assistant Commissioner of Policy, Planning and Consumer Services; and
    - e. Submit requests on a form approved by the DMRS Central Office.
  3. At least 24 hours prior to a monthly meeting of the DMRS Central Office Intake Review Committee, the Office of Community Services shall prepare and distribute to each Committee member a packet that includes the completed ***Request to Begin or Continue the Waiver Enrollment Process*** forms that were submitted by the Regional Offices for review.
  4. The DMRS Central Office Intake Review Committee shall:
    - a. Review the information submitted by the Regional Offices on a case by case basis, taking into consideration the person's current situation including living arrangements, lack of a place to live, whether there is serious and imminent danger of harm to self or to others by the person, and whether or not the person's caregiver continues to be able to provide adequate assistance to keep the person healthy and safe; and
    - b. Make a determination regarding who and how many may be approved to begin or continue the enrollment process based on the availability of funding.
  5. Within 2 working days following a monthly or ad hoc meeting of the DMRS Central Office Intake Review Committee, the Office of Community Services shall notify the applicable Regional Office of the Committee's determinations and shall notify the case managers, as appropriate, of any additional actions that may be required. The Office of Community Services shall provide the Regional Office with a copy of the completed ***DMRS Central Office Intake Review Committee Disposition Form*** (attached) for each person reviewed.
  6. Within 14 working days after being notified that the service recipient's request to begin or continue the enrollment process was not approved, the service recipient or the service recipient's legal representative may submit a written request to the DMRS Deputy Commissioner for reconsideration. The request will be reviewed and notice of the reconsideration decision will be made within 14 working days.
  7. The DMRS Central Office Intake Review Committee shall be made up of DMRS staff designated by the Deputy Commissioner and shall include the following:
    - a. Deputy Commissioner, Chair
    - b. Assistant Commissioner of Community Services
    - c. Assistant Commissioner of Policy, Planning, and Consumer Services
    - d. Medical Director of the Clinical Unit
    - e. Medical Director for Policy and Governmental Relations, Vice-Chair
    - f. Director of Support Coordination and Case Management
    - g. Director of Operations
    - h. Director of Protection from Harm
    - i. Director of the Office of Consumer and Family Services
  8. The DMRS Central Office Intake Review Committee meetings shall be held monthly or more frequently as needed. Three members shall constitute a quorum for the regular monthly meeting.
  9. A Regional Director may submit a request at any time for an ad hoc review for an individual who is in extreme crisis. Requests for ad hoc review should be sent to the Assistant Commissioner of Community Services with a copy to the Assistant Commissioner of Policy, Planning, and Consumer Services.

10. A list of DMRS Central Office Intake Review Committee members participating in the meeting shall be kept. Copies of the justification information provided by the Regional Offices and the DMRS Central Office Intake Review Committee's determinations shall also be maintained and will serve as meeting minutes. These records shall be maintained by the Office of Community Services.

E. ATTACHMENTS

1. Request to Begin or Continue the Waiver Enrollment Process
2. DMRS Central Office Intake Review Committee Disposition Form

F. PREVIOUS POLICY N/A

G. DATE APPROVED BY TENNCARE: July 17, 2007

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H. POLICY APPROVAL

  
\_\_\_\_\_  
Signature of Assistant Commissioner  
Office of Policy, Planning, and Consumer Services

7/18/07  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Signature of Deputy Commissioner  
Division of Mental Retardation Services

7/20/07  
\_\_\_\_\_  
Date

**REQUEST TO BEGIN OR CONTINUE  
THE WAIVER ENROLLMENT PROCESS**

Revised 7-5-2007

Referral  Initial request  
 Status  Repeat request  
 Request for urgent review

Name of Applicant \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

Current Status  State Funded Only  
 "Self-Determination" Waiver  
 "Statewide" Waiver  
 None of above

Case Manager Information Name \_\_\_\_\_  
 Phone \_\_\_\_\_  
 E-mail \_\_\_\_\_

Regional Office  WTRO  MTRO  ETRO  
 Requested Waiver  Self-Determination  "Statewide"  "Arlington"  
 Referral Source  Waiting List  DCS >18  PASARR  Mental Health Institute

Medicaid Approved  Yes  No  
 PAE Approved  Yes  No  
 Financially Eligible, DHS  Pending  Approved  
 Priority Ranking  Very high  High  Moderate

**Check Yes or No. Provide details in the justification attachment.**

- |                              |                          |  |
|------------------------------|--------------------------|--|
| <b>YES</b>                   | <b>NO</b>                |  |
| 1. <input type="checkbox"/>  | <input type="checkbox"/> | Did the primary caregiver die?   |
| 2. <input type="checkbox"/>  | <input type="checkbox"/> | Has or will the primary caregiver become incapacitated and unable to provide care? If incapacitation is short term (e.g., recovery from surgery), specify how long: _____      |
| 3. <input type="checkbox"/>  | <input type="checkbox"/> | Is the primary caregiver unable to provide an acceptable level of care due to also caring for other persons with serious mental or physical disabilities?                      |
| 4. <input type="checkbox"/>  | <input type="checkbox"/> | Does the primary caregiver have to work to provide the primary income for the family?  |
| 5. <input type="checkbox"/>  | <input type="checkbox"/> | If the answer is "Yes" to any of the above 4 questions, is there an alternate primary caregiver or caregivers?   |
| 6. <input type="checkbox"/>  | <input type="checkbox"/> | Is the person homeless now?  |
| 7. <input type="checkbox"/>  | <input type="checkbox"/> | Will the person become homeless soon? If so, specify how soon: _____   |
| 8. <input type="checkbox"/>  | <input type="checkbox"/> | Does the person's current behavior pose a serious and imminent danger of self-harm or of danger of harm to others which cannot be reasonably managed by the primary caregiver? |
| 9. <input type="checkbox"/>  | <input type="checkbox"/> | Has a referral been made to Adult Protective Services or Children's Protective Services?   |
| 10. <input type="checkbox"/> | <input type="checkbox"/> | <b>Children &lt; age 21:</b> is the child in DHS custody or receiving family preservation in the home?   |
| 11. <input type="checkbox"/> | <input type="checkbox"/> | Does the person require 24-hour services in a setting other than the family home?  |

**REQUESTED SERVICES:** List the specific waiver services (with amount/frequency) that are needed.

**JUSTIFICATION:** Attach a brief description of the situation and give details to justify the immediate need for services.

