If meeting the previously mentioned deliverables is delayed due to the individual (or family) failing to comply with attending meetings, participating in mandated contacts, allowing access to the home for visits, etc., the Support Coordinator should notify the individual that non-compliance regarding Division policy will be reported to the Division. If non-compliance continues, the SC Supervisor shall upload a Seeking Out Support (SOS) form and email the Support Coordination Help Desk at DDD.SCHelpdesk@dhs.nj.gov to ensure follow-up with the individual to determine the reasons why non-compliance has occurred. Ongoing non-compliance for circumstances beyond those that may be unavoidable (such as hospitalization) may result in disenrollment from Division services and/or the CCP. Information regarding these incidents of non-compliance, attempted or successful contacts with the individual (or family), reasons for non-compliance, etc. shall be documented through case notes entered into iRecord.

Updates related to any and all significant events should be documented in case notes by the Support Coordinator. Documentation should be timely and frequent for high risk or high acuity situations. Case Notes shall be up to date at all times with the most recent contact or events occurring with the individual.

If meeting these deliverables is delayed due to system issues with the Division, the SC Supervisor shall notify the Support Coordination Help Desk at DDD.SCHelpdesk@dhs.nj.gov.

6.5 Community Transitions & Support Coordination

6.5.1 Transitions to Institutions from Community Settings

When an individual is transitioned from a community setting into an institutional setting (nursing home, ICF/ID, etc.) for the purpose of rehabilitation, respite, etc. if there is an assigned Support Coordinator, the Support Coordinator will retain the case up to 180 days from the date of admission. As appropriate, the Support Coordinator shall complete needed placement efforts. The Support Coordinator must then transition the individual to a Division Case Manager.

This transition will proceed as follows:

- Support Coordination will complete monthly monitoring in accordance with established Support Coordinator Responsibilities and Deliverables as described in Section 13.
- Support Coordination will conduct all placement activities to transition the individual back to the community if the individual is returning to their original placement or a new placement is identified.
- If the individual has not transitioned after being in an institutional setting for 180 days, Support Coordination will transfer the case to a Division Case manager to complete the transition using the Community Transitions Unit Case Transfer Form (Appendix D).
    - Support Coordination will forward request to have case assigned to the assigned Division Monitoring Team through the DDD SC Helpdesk.
    - The assigned Division Monitoring Team will forward the form to the Community Transitions Unit.
    - The case will be reassigned in iRecord from the Support Coordination Agency to the Division.
    - The Community Transitions Unit will then be responsible for all placement activities.
- If long term placement in a Skilled Nursing Facility (SNF) occurs, an individual will be placed on an inactive caseload as they will no longer be eligible for Waiver services.

6.5.2 Transitions from Institutional to Community Settings

When an individual moves from an institutional setting (nursing home, developmental center, ICF/ID, etc.) to a community placement, a transition from a Division Case Manager to a Support Coordinator in the community may take place. This transition will proceed as follows:

- Before discharge from the institution, the Division Case Manager will develop a service plan that remains in place for 90 days.
- The Division Case Manager will continue to work with the individual for a period of 90 days from the date of the community placement.
- Upon placement in the community, the individual will select a Support Coordination agency (or be auto-assigned based on preference) following Support Coordination selection procedures described in Section 6.1.2.
- 30 days following the date of the community placement, a Support Coordinator will be assigned to overlap with the Division Case Manager for the remaining 60 days to ensure continuity of care.

- The Division Case Manager will be the primary person responsible for the transition during the first 60 days, after which the Support Coordinator will become the primary person responsible for the individual's transition and service planning process. The Case Manager will be responsible for ensuring the Support Coordinator is apprised of the individual's background, important health indices, and any other pertinent information during a case review before the 60-day period ends. The Case Manager will provide support and assistance to the Support Coordinator to ensure a smooth transition of care management services.
- The Support Coordinator will be responsible for developing a new service plan within the first 30 days of assignment and then monitoring every 30 days thereafter in accordance with established Support Coordinator Responsibilities and Deliverables as described in Section 13. This may include the completion of required surveys.
- At the conclusion of 90 days, the Division Case Manager will be removed from the case unless serious health and safety issues warrant a longer transition period. The Support Coordinator will then be solely assigned and responsible for the monitoring of the individual and the new service plan will commence.
- Upon the approval of the Support Coordinator service plan billing will shift from Case Management to Support Coordination. At no time will both services be claimed.

Days	Care Management Roles
0 – 30 Days	Division Case Manager responsible, Support Coordination Agency selected
0 – 60 Days	Division Case Manager responsible, Support Coordinator assigned after 30 days
60 – 90 Days	Support Coordinator responsible, Division Case Manger providing assistance
90 + Days	Support Coordinator responsible, Division Case Manager removed

6.5.3 Transitions from Community Settings to Hospitalization

When an individual already utilizing Support Coordination services is placed in an institutional setting, the Support Coordinator continues to provide services for up to 30 days. When an institutional setting placement lasts more than 30 days, but is considered short term, the Support Coordinator must transition the individual to a Division Case Manager for monitoring. If long term placement in a Skilled Nursing Facility (SNF) occurs, an individual will be placed on an inactive caseload as they will no longer be eligible for CCP service. This transition will proceed as follows:

- Prior to the 30th day of hospitalization, the Support Coordination Supervisor must notify the assigned Division staff of the potential need for Division Case Management assignment.
- On the 30th day of any institutional placement the Support Coordinator must notify CCP staff of the placement because, depending upon the situation, the CCP staff may need to terminate the CCP status in order for the institutional setting to be paid.
- Once the Division Case Manager is assigned, the Support Coordinator must ensure that the Case Manager is apprised of the individual's background, important health indices, and any other pertinent information during a case review, and revise the service plan to stop any ongoing services.
- The Division Case Manager will then be responsible for the continued monitoring including, if applicable, re-enrollment onto the CCP. During this time, the Support Coordination Agency cannot bill for Support Coordination services.
- Upon discharge from an institutional setting beyond 30 days, the procedure for Transitions from Institutions to Community Placement will be followed to ensure continuity of care during the transition back to Support Coordination. The discharge date will begin the 90-day transition period and the Support Coordinator will revise the service plan as applicable as described in Section 7.9.

Individuals eligible for Division services who reside in an SNF long term but elect to move to a community setting supported by the Division should contact the Division's Intake Unit as outlined in section 3.2.