



ACCESS GUIDELINES TO  
STATE SERVICES FOR  
PERSONS WITH TRAUMATIC  
BRAIN INJURY

*Version 5*



## Acknowledgements

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*Michigan Department  
of Community Health*



STATE OF MICHIGAN  
**Family  
Independence  
Agency**





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**SECTION I.**  
**INTRODUCTION**





## Purpose of this Document

Approximately 1.5 million Americans are involved in motor vehicle collisions, falls, recreation activities, and violence related events that result in a traumatic brain injury (TBI) each year. Nationwide, more than 50,000 people die annually due to TBI and 5.3 million U. S. citizens, or two percent of the population, live with a disability resulting from TBI.<sup>1</sup> TBI is the leading cause of death and disability in persons under the age of 18 and males are twice as likely as females to acquire a TBI.<sup>2</sup>

In June of 1999, the need to develop a plan regarding TBI was identified as a result of a state department assessment on TBI in Michigan, and the following challenge was set:

“Develop a community-based, coordinated system to provide an array of services... to all persons with TBI. Because individuals with TBI can have such different types of needs and levels of impairment, planning for a system of care should address the use of supports coordination to link people with appropriate services to address individual needs and to assist with navigating the system.”<sup>3</sup>

The goal of the *Access Guidelines to State Services for Persons with Traumatic Brain Injury (Access Guidelines)* is to help providers to know when and how to direct persons with TBI to other agencies and to ensure access and coordination of services. The *Access Guidelines* are the first step in the process of recommending a system of service coordination between the state agencies listed below.

## How to Use these Access Guidelines

The *Access Guidelines* describe services relevant to persons with TBI from five public agencies:

- ▶ Michigan Department of Community Health – Mental Health and Substance Abuse Services Administration
- ▶ Family Independence Agency (FIA)
- ▶ Michigan Department of Community Health – Long Term Care (LTC)
- ▶ Michigan Department of Education – Office of Special Education and Early Intervention Services
- ▶ Department of Labor & Economic Growth – Michigan Rehabilitation Services

The *Access Guidelines* are designed to be used in conjunction with the *Michigan Resource Guide for Persons with Traumatic Brain Injury and their Families (MRG)*, which is a comprehensive guide for finding services in the state of Michigan. The MRG includes information on services offered by all levels of government as well as non-profit

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<sup>1</sup> National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (1999, Dec). Traumatic Brain Injury in the United States: A Report to Congress. Available: <http://www.cdc.gov/doc.do/id/0900f3ec8001011c>.

<sup>2</sup> Rehabilitation of Persons with Traumatic Brain Injury. *Epidemiology of Traumatic Brain Injury*. NIH Report of the Consensus Development Panel. 1998 Oct 26-28: 27.

<sup>3</sup> Michigan Traumatic Brain Injury - Results of the State Department Assessment. June 1999.

organizations. Please refer to the MRG for additional descriptions of the services listed in these *Access Guidelines* and for information on many other services offered throughout the state. (Information on how to obtain copies of the MRG is listed below.)

Some services for children are included in these *Access Guidelines*, but many services for children are available, including Children's Special Health Care Services and the Children's Waiver Program. For information on additional services available for children and adults, please refer to the MRG.

The contents of the guide are broken down for each agency into the following sections:

- ▶ Overview of Services: a table that provides a simple overview of services offered.
- ▶ Description of Services: information about services provided.
- ▶ Contacting the Office or Service Provider: includes information on how to get in touch with an agency, how to address special communication needs and information on transportation services.
- ▶ Determination of Needs and Eligibility: explains the process of determining eligibility for services and identifying individual needs.
- ▶ Decision Tree: a figure that graphically depicts the beginning of the eligibility determination process.
- ▶ How to Appeal a Determination: provides information on how to begin the appeal process if there is disagreement on determination of eligibility or services provided.

Each of the agencies discussed in these *Access Guidelines* will share information regarding a consumer with other agencies or organizations if the consumer or the consumer's guardian has signed a release form.

The *Michigan Resource Guide for Persons with Traumatic Brain Injury and their Families* (MRG) may be downloaded free of charge in English, Spanish or Arabic from the following website: [www.michigan.gov](http://www.michigan.gov) (search for "traumatic brain injury").

To order copies of the MRG, contact:

Brain Injury Association of Michigan  
8619 West Grand River Road, Suite I  
Brighton, MI 48116  
Phone: (800) 772-4323  
Fax: (810) 229-8947  
Or,  
Michigan Public Health Institute  
2440 Woodlake Circle, Suite 190  
Okemos, MI 48864  
Phone: (517) 324-8398  
Fax: (517) 324-6099

**SECTION II.**

**MICHIGAN DEPARTMENT OF COMMUNITY  
HEALTH - MENTAL HEALTH AND  
SUBSTANCE ABUSE SERVICES ADMINISTRATION**





## Community Mental Health Services Programs (CMHSP)

**Table 1: Overview of Community Mental Health Services for Children and Adults**

<b>Community Mental Health Services</b>	<b>Eligibility</b>	<b>Contact</b>
Case Management	Severity and Income/Asset Criteria	Local CMHSP
Individual/Family/Group Therapy	Severity and Income/Asset Criteria	Local CMHSP
Medication Administration and Review	Severity and Income/Asset Criteria	Local CMHSP
Crisis Intervention Services	Severity and Income/Asset Criteria	Local CMHSP
Applied Behavioral Services	Severity and Income/Asset Criteria	Local CMHSP
Mental Health Emergency Services	Severity and Income/Asset Criteria	Local CMHSP
Inpatient Psychiatric Services	Severity and Income/Asset Criteria	Local CMHSP
Assertive Community Treatment (ACT)	Severity and Income/Asset Criteria	Local CMHSP
Assessments	Severity and Income/Asset Criteria	Local CMHSP
Crisis Residential Services	Severity and Income/Asset Criteria	Local CMHSP
Enhanced Health Services	Severity and Income/Asset Criteria	Local CMHSP
Mental Health Home-based Services	Severity and Income/Asset Criteria	Local CMHSP
OT, PT, Speech Evaluation	Severity and Income/Asset Criteria	Local CMHSP
Treatment Planning	Severity and Income/Asset Criteria	Local CMHSP
Transportation to Day Program	Severity and Income/Asset Criteria	Local CMHSP

### Description of Community Mental Health Services

Community Mental Health Services Programs (CMHSP) are contracted by the State of Michigan Department of Community Health to provide a full array of community-based support services for eligible individuals and their families. While some CMHSPs may directly operate treatment programs, most CMHSPs establish a network of agencies and professionals to provide treatment services. There are a number of covered services that the CMHSPs are required to provide, including the following:

**Case Management** Case management services assist mental health clients in gaining access to needed medical, social, educational, financial and other services. Core elements of case management include assessment, development of an individual plan of service, linking or coordination of services, re-assessment/follow up and monitoring of services.

**Individual/Family/Group Therapy** Therapy is a treatment activity designed to reduce maladaptive behaviors, restore normalized psychological functioning and improve emotional adjustment and functioning.

**Medication Administration and Review** Medication administration and review services are provided by a psychiatrist for the purposes of evaluating and monitoring medications and their effects.

**Crisis Intervention Services** Crisis intervention services consist of face-to-face or phone contact with an individual for the purpose of resolving a crisis or emergency situation requiring immediate attention.

**Applied Behavioral Services** Behavioral services are actively designed to reduce maladaptive behaviors, to maximize behavioral self control or to restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the individual to function more appropriately in interpersonal and social relationships.

**Mental Health Emergency Services** Emergency services offer 24-hour crisis intervention to persons experiencing a psychiatric crisis. In an emergency, consumers can call the mental health 24-hour crisis line listed in the phone book under "Mental Health". Individuals with an emergency may walk into any mental health location or hospital emergency room for immediate treatment. Services available include assessment and referral, and screening for psychiatric hospitalization of Medicaid and uninsured consumers.

**Inpatient Psychiatric Services** Inpatient psychiatric services are provided around the clock in a hospital setting.

**Assertive Community Treatment (ACT)** ACT is a comprehensive and integrated set of medical and psychosocial services provided on a one to one basis primarily in the client's residence or other community locations by a mobile multidisciplinary mental health treatment team.

**Assessments (health, psychiatric, psychological testing)** Assessments are comprehensive evaluations of the physical, cognitive, behavioral or emotional needs/status of a client that may result in the initiation of a specific CMHSP service, additional assessment/consultation or referral to an appropriate community resource.

**Crisis Residential Services (short-term alternative to inpatient psychiatric services)** Intensive residential services provide a short-term alternative to inpatient psychiatric services for persons experiencing a psychiatric crisis.

**Enhanced Health Services** Health-related services that are beyond the responsibility of the consumer's health plan are provided for rehabilitative purposes to improve overall health and ability to care for health-related needs.

**Mental Health Home-Based Services** Family focused intensive services are provided to individuals and families with multiple service needs who require access to an array of mental health services.

**Occupational Therapy (OT), Physical Therapy (PT), Speech Evaluation** OT, PT and speech services are provided by a licensed professional or assistant to assist with achieving optimum functioning.

**Treatment Planning** Activities associated with the development and periodic review of an individual plan of service are organized, including all aspects of person centered planning as well as pre-meeting activities.

**Transportation to Day Program** Transportation is provided to and from the consumer's residence, so a consumer may participate in a covered day program or psychosocial rehabilitative program.

## **Contacting the Office**

Contact information for local CMHSPs can be found in the phone book under "Mental Health" or "County Government" in the yellow pages, or by calling Information. The Michigan Association of Community Mental Health Boards (MACMHB) also provides local CMHSP information at (517) 374-6848. If it is not an emergency, an initial screening over the phone or in person will be done to determine eligibility and, if eligible, an appointment/treatment will be arranged.

A TTY should be requested for persons with a hearing impairment. Translation will be available for those with limited English proficiency. These services must be made available to the consumer within 24 hours of contact.

Transportation services are specific to individual treatment agencies. The treatment agency may be able to coordinate transportation with local transportation providers. FIA is a provider for transportation to medically required appointments for persons who are Medicaid eligible.

## **Determination of Needs and Eligibility**

There are three ways persons with TBI may qualify for CMHSP services: being classified as having a developmental disability, mental illness or substance abuse problem. Eligibility determination may begin with a brief phone screening, followed by a face-to-face psychosocial assessment. Documentation and information on the presenting problem, history of problems, prior treatment and current symptoms, as well as current insurance and financial information, may be necessary to determine eligibility and needs. Residency and degree of impairment are considered in determining eligibility.

Typically, only one contact is necessary to determine a consumer's needs. Additional services such as psychological testing, psychiatric evaluation or further assessments may be required to determine diagnosis and course of treatment.

Once a consumer is determined to be eligible for services, an individual plan of services is developed using a person centered planning process tailored to the individual's needs. At that time, consumers will be offered a choice of providers who are under contract with the CMHSPs. Services must be provided within 14 days of the assessment.

*Eligibility Determination for Persons with a Developmental Disability<sup>4</sup>:*

For individuals older than five years, a developmental disability is a severe, chronic condition that meets all of the following requirements:

A) is attributed to a mental or physical impairment or a combination of physical and mental impairments

B) is manifested before the individual is 22 years old

C) is likely to continue indefinitely

D) results in substantial functional limitation in three or more of the following areas of major life activities:

- self care
- receptive and expressive language
- learning
- mobility
- self direction
- capacity for independent living
- economic self sufficiency

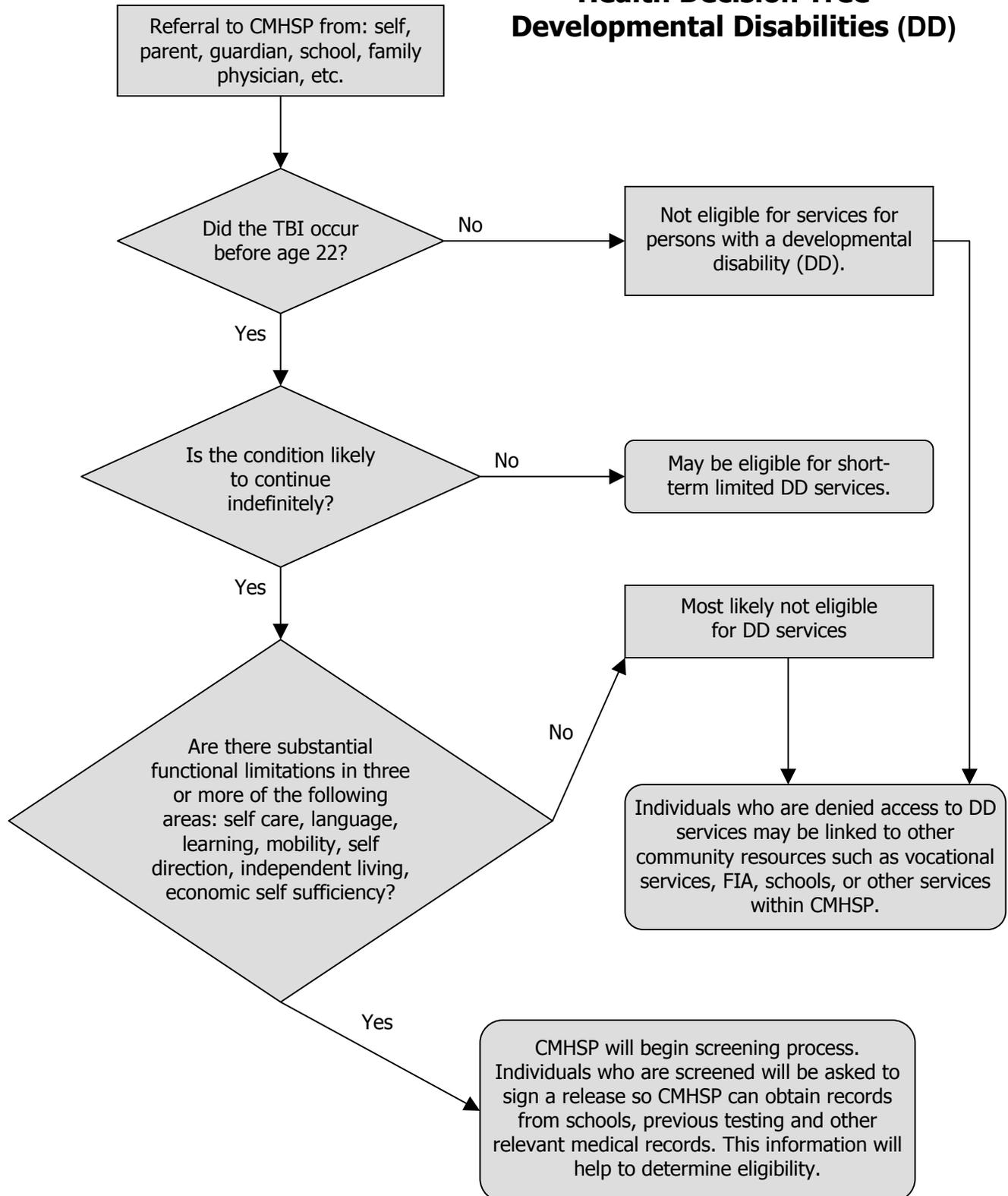
E) reflects the individual's need for a combination and sequence of special, interdisciplinary or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

For minors from birth to age five, a developmental disability is a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in item (A) if services are not provided.

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<sup>4</sup> Persons with TBI may be classified as having a developmental disability.

**Figure 1: Community Mental Health Decision Tree - Developmental Disabilities (DD)**



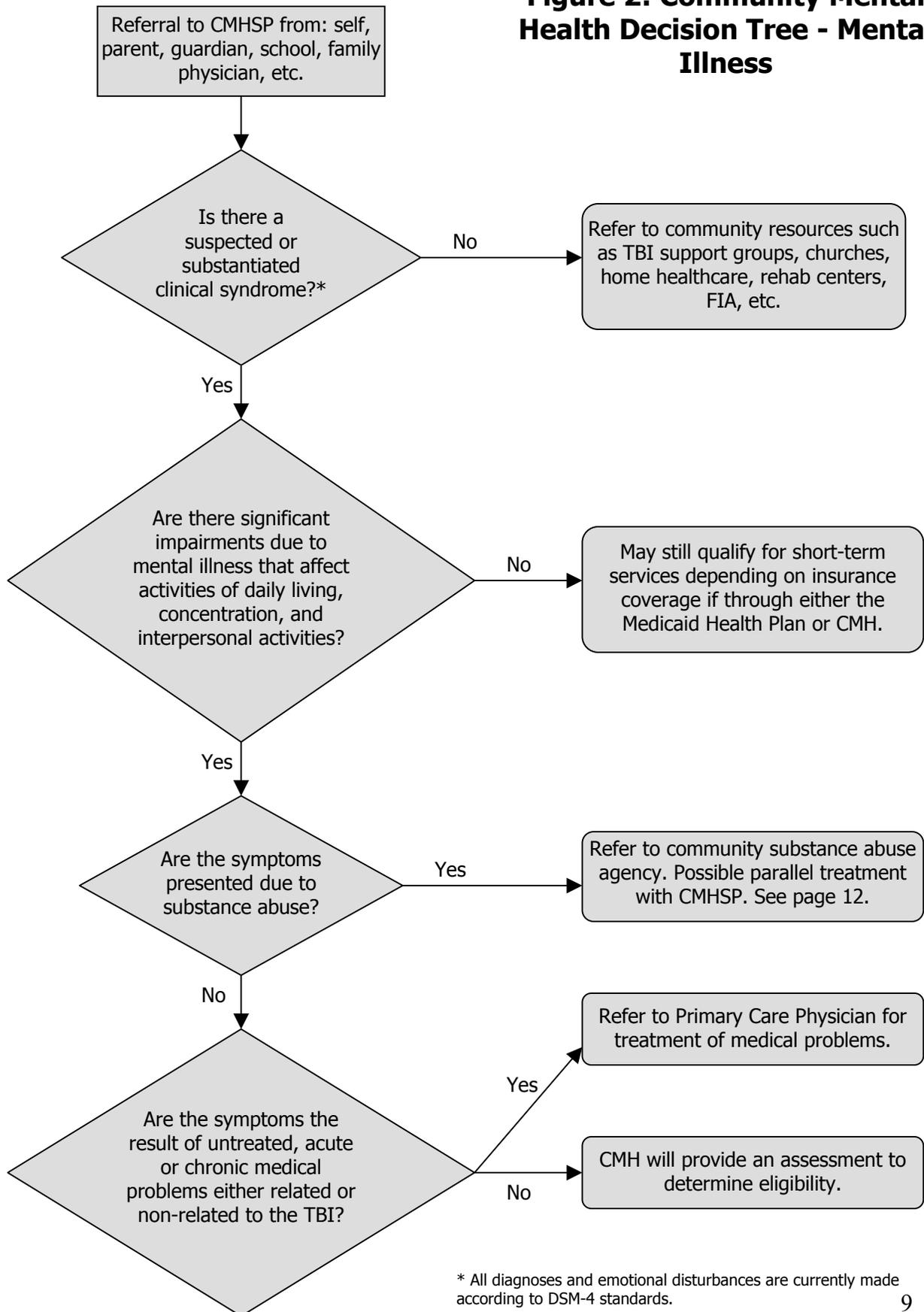
*Eligibility Determination for Mental Illness:*

A variety of methods may be employed to make determinations regarding the presence of mental illness and any medically necessary services. The determination of medically necessary services must be based on a person-centered planning process. Co-occurring substance use disorders or underlying medical conditions, such as TBI, should be evaluated and treated.

How mental illness affects other areas of a consumer's life (e.g., activities of daily living, concentration, interpersonal activities) is also considered in making the assessment of need for services.

When determining the presence and severity of mental illness, the presence of additional physical illness/medical problems or substance abuse problems needs to be considered for accurate diagnosis and effective treatment.

**Figure 2: Community Mental Health Decision Tree - Mental Illness**



\* All diagnoses and emotional disturbances are currently made according to DSM-4 standards.

## Substance Abuse (SA) - Access, Assessment and Referral Agencies (AAR)/Central Diagnostic and Referral Agencies (CDR)

**Table 2: Overview of Substance Abuse Services**

<b>Substance Abuse Services</b>	<b>Eligibility</b>	<b>Contact</b>
Outpatient Services ▶ Individual Therapy ▶ Group Therapy ▶ Family Therapy	Diagnosed substance abuse/addiction	Substance Abuse Coordinating Agency or Local CMHSP
Intensive Outpatient Services	Diagnosed substance abuse/addiction	Substance Abuse Coordinating Agency or Local CMHSP
Residential Services ▶ Detoxification Services ▶ Short-Term Residential Services ▶ Long-Term Residential Services	Diagnosed substance abuse/addiction	Substance Abuse Coordinating Agency or Local CMHSP

### Description of Substance Abuse Services

The Michigan Department of Community Health, through its regional authorities, contracts with Access, Assessment and Referral Agencies (AARs), formerly known as Central Diagnostic and Referral Agencies (CDRs), throughout the state to provide access to alcohol and drug abuse services. AARs/CDRs provide screening and arrange for placement in appropriate services. An AAR/CDR must screen individuals who receive public funding before the individual may enter a treatment program. AARs/CDRs and providers focus on individual needs through person centered planning to determine treatment. Continuum of care may include:

#### Outpatient Services

- ▶ Individual Therapy – Face-to-face counseling services are available for the consumer or the consumer’s significant other.
- ▶ Family therapy – Face-to-face counseling with the consumer and his/her significant other and/or traditional or nontraditional family members is provided.
- ▶ Group Therapy – AARs/CDRs provide face-to-face counseling with three or more clients that can include didactic lectures, therapeutic discussions and other group related activities.

**Intensive Outpatient Services** Services are provided multiple days per week over a specified time period as determined by program design and the client’s needs.

#### Residential Services

- ▶ Detoxification – Medically supervised care is provided in a sub-acute residential setting for the purpose of managing the effects of withdrawal from alcohol and/or other drugs. A detoxification program must be staffed 24 hours per day, seven days per week, by a licensed physician or by the designated representative of a licensed physician. Services typically last three to five days.

- ▶ Short-Term Residential – Planned individual and/or group therapeutic and rehabilitative counseling and didactics are provided as an intense, organized, daily treatment regimen in a residential setting which includes an overnight stay. These programs have trained treatment staff supervised by a professional who is responsible for the quality of care. Such programs are typically 30 days or fewer.
- ▶ Long-Term Residential – This professionally supervised program includes planned individual and/or group therapeutic and rehabilitative counseling, didactics, peer therapy, and rehabilitative care. These services are provided in a residential setting and include an overnight stay. Such programs typically are longer than 30 days.

## **Contacting the Office**

The Michigan Resource Center, (800-626-4636), will provide local AAR/CDR office information. When calling, an electronic menu will answer. "Other options" should be selected to talk to a person. Local information is also available in the phone book under "Substance Abuse" in the yellow pages. If it is not an emergency, an initial screening over the phone or in person will be done to determine eligibility and, if eligible, an appointment/treatment will be arranged. A referral will also be offered to eligible persons who walk into a location. Persons having substance related emergencies should visit the nearest emergency care unit of a local hospital.

A TTY should be requested for persons who have a hearing impairment, and translation will be available for those with limited English proficiency. TTY services must be made available to the consumer within 24 hours of contact.

Transportation services for meetings/appointments are specific to individual treatment agencies. The treatment agency may be able to coordinate transportation with local transportation providers.

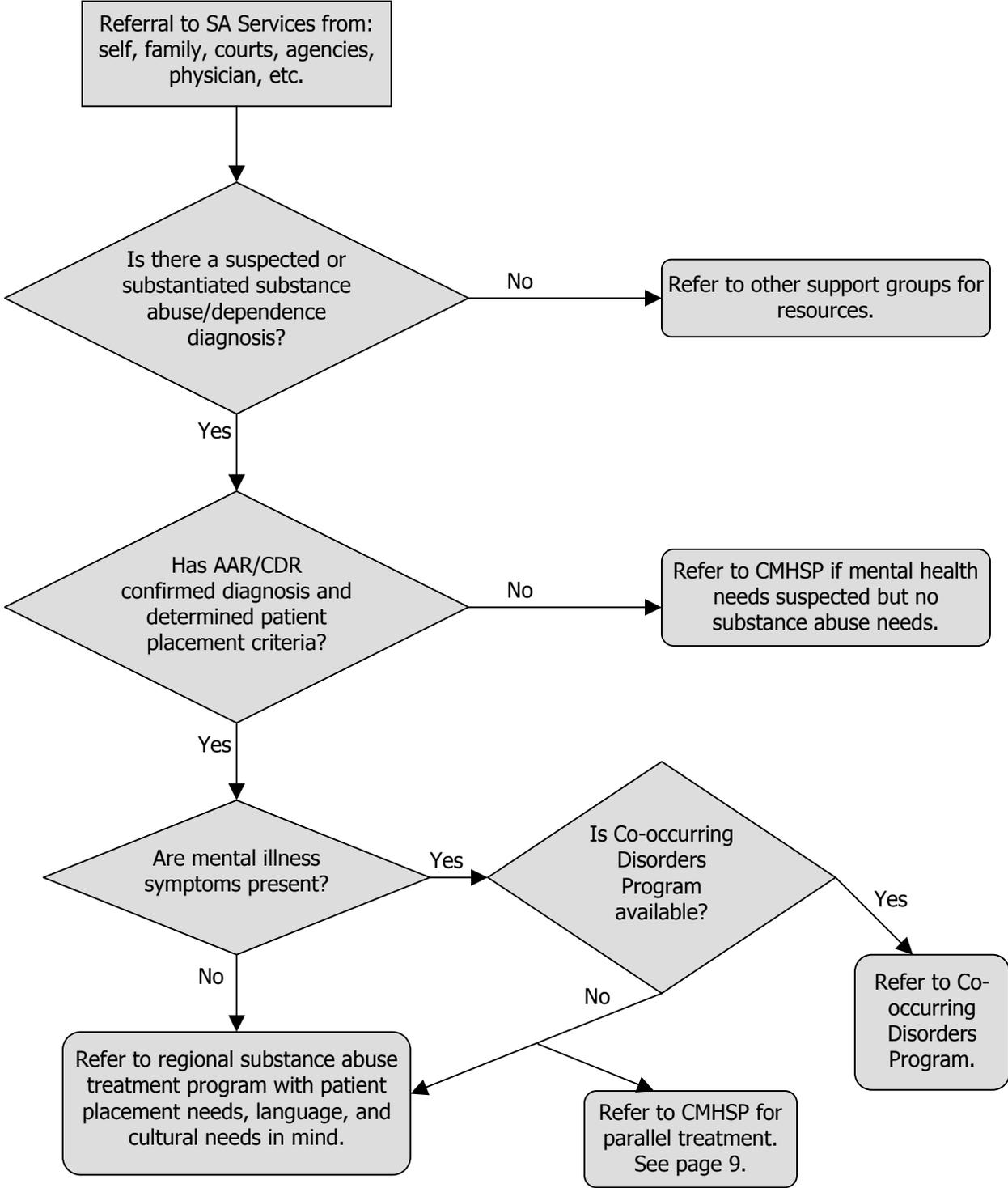
## **Determination of Needs and Eligibility**

Individual needs are determined using standardized screening instruments and Patient Placement Criteria over the phone or in person. One or more contacts may be necessary before needs and eligibility are determined.

Eligibility requires a diagnosed substance abuse or addiction disorder and a need for publicly funded services. The consumer should be prepared to present documentation and information of financial status, current insurance, history of prior treatment and current substance use as requested to determine eligibility and needs.

Eligibility is typically determined during the first phone call or interview. Service provision is based on availability and acuity of needs. If the consumer is in crisis while waiting for services, he/she should call the treating agency to receive proper care or go to the nearest emergency care unit of a local hospital.

**FIGURE 3: Substance Abuse (SA)/Dependence Decision Tree**



## **How to Appeal a CMHSP or SA Determination**

If a consumer disagrees with the determination of eligibility for services, the consumer has the right to appeal the decision and should receive written instructions from the treating agency with their determination notification on how to proceed with the appeal. A consumer has the right to engage an advocate or lawyer at any time during the process.



**SECTION III.**  
**FAMILY INDEPENDENCE AGENCY**





## Family Independence Agency (FIA)

**Table 3: Overview of FIA Services**

<b>Family Independence Agency Services</b>	<b>Eligibility</b>	<b>Contact</b>
<b>Adult Services</b>		
▶Independent Living Services	None – Information and referral available to anyone. There are no public resources to pay for services.	Local FIA Office-Adult Services Unit
▶Home Help Services	Must be Medicaid eligible with a functional limitation-no age requirement	Local FIA Office-Adult Services Unit
▶Adult Community Placement	Must be Medicaid eligible and meet age requirements	Local FIA Office-Adult Services Unit
▶Adult Protective Services	None	Local FIA Office-Adult Services Unit
▶ Physical Disabilities Services	Must be Medicaid eligible, have an open case with adult services, have a documented medical need and no other coverage	Local FIA Office-Adult Services Unit
<b>Eligibility Determination</b>		
▶Medicaid (MA) (Includes MI Child & Healthy Kids)	Low income/asset	Local FIA Office-Medicaid Eligibility
▶Adult Medical Program	Single Adult not on Medicaid, low income/asset requirements	Local FIA Office-Medicaid Eligibility
▶State Disability Assistance	Check with local FIA Office	Local FIA Office-Medicaid Eligibility
▶Family Independence Program (FIP)	Income, asset and family composition	Local FIA Office-FIP Staff
▶Food Assistance/Bridge Card	Income and asset criteria	Local FIA Office-FIP & ES Staff

### Description of FIA Services

#### Adult Services

- ▶Independent Living Services - FIA provides services to enhance independence and self-sufficiency.
- ▶Home Help Services - This is an in home program to assist with activities of daily living to enable a person to remain in an independent living situation.
- ▶Adult Community Placement Services - This program assists persons with making informed decisions about out-of-home living arrangements (adult foster care & home for the aged) when independent living is not possible. A Personal Care/Supplemental payment may be available to cover some of the costs of those living arrangements if the customer is on Medicaid.
- ▶Adult Protective Services - FIA staff investigate complaints of abuse, neglect and exploitation of vulnerable adults and provide linkage to needed community services.

- ▶Medical Equipment and Assistive Technology - FIA provides information about sources of medical equipment and, in some cases, can provide payment for equipment and/or services that are not covered by Medicaid through Physical Disability Services.

### **Eligibility Determination Services**

FIA offices determine eligibility for the federal Medicaid insurance programs. For a listing of all Medicaid categories and unique non-financial eligibility factors for each category, see the "Medicaid Overview" (Appendix 1).

- ▶Medicaid - See the "Medicaid Overview" (Appendix 1). Persons qualifying for Supplemental Security Income (SSI) are automatically eligible for Medicaid. Persons who might qualify for SSI should be referred to Social Security Administration.
- ▶Adult Medical Program – FIA determines eligibility for the Adult Medical Program, which may cover basic medical care and mental health services to single lower income individuals between the ages of 18 and 65 who do not qualify for other Medicaid programs.
- ▶State Disability Assistance (SDA) Program - FIA determines eligibility for the SDA Program through which a customer can receive a monthly grant. The customer must be determined to have a disability that is expected to last at least 90 days but not more than one year.
- ▶Family Independence Program (FIP) - FIP provides financial assistance to families with children. The goal of FIP is to maintain and strengthen family life for children and the parents or other caretaker(s) with whom they are living, and to help the family attain or retain capability for maximum self-support and personal independence.
- ▶Food Assistance Program (FAP)/Bridge Card - The purpose of this program is to raise the food purchasing power of low-income persons. Benefits are issued using electronic technology and a debit card known as the Bridge Card.

### **Contacting the Office**

Customers should call their local FIA office listed in the phonebook under "State Government" or "County Government" and ask for the Adult Services Unit, or visit the website: [www.michigan.gov/fia](http://www.michigan.gov/fia). An Adult Service worker will be able to refer callers to the appropriate person. An FIA worker may be assigned to work with the customer at that time. Any applicant has the right to bring with them an advocate to assist in the application process.

TTY is available in all FIA offices to address any speech impairments. FIA staff persons can make home visits and may arrange for transportation to medically required appointments for persons who are medically eligible.

## **Determination of Needs and Eligibility**

A caseworker is provided to assist with determining eligibility for Medicaid, Adult Medical Program and other financial programs; a case manager is provided to assist with eligibility determination for adult and child Services Programs. Customers should call a local FIA office and ask whom to speak to about eligibility determination, as processes can vary from one FIA office to another.

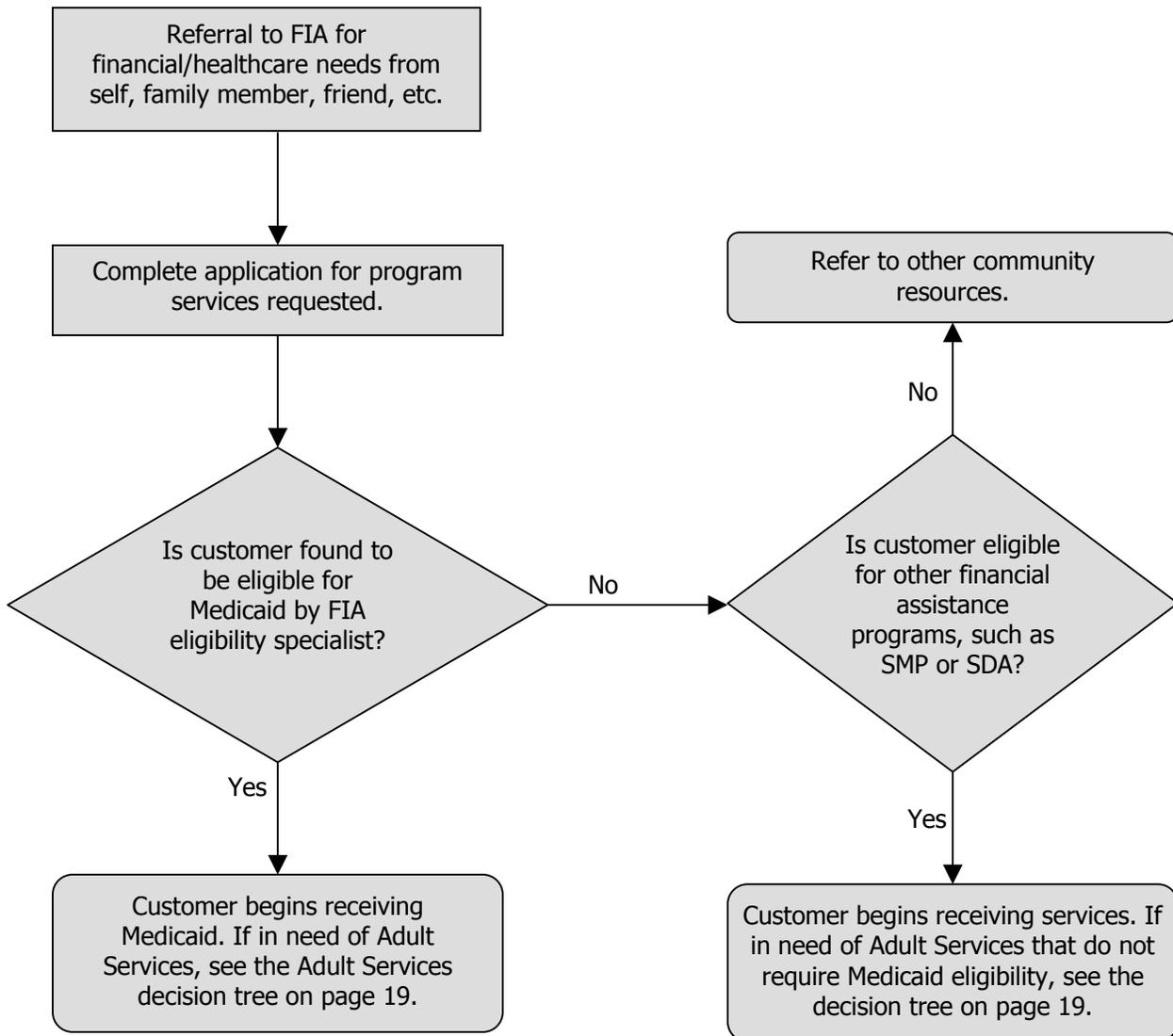
Eligibility criteria for each FIA service are different. Eligibility is based on such factors as income, assets, health and/or living situation. Because staff workers in local FIA offices are specialized, and cover financial and Medicaid (and Adult Medical) programs as well as other services (adult, children<sup>5</sup>), it is best if the customer asks for the program in which they are interested by name. This is especially important in the larger FIA county offices that have multiple locations, each of which may not cover all available services in that county. Customers should call the main phone number for their county FIA to find out which office offers the program in which they are interested. Documentation needed to determine eligibility and needs may vary for each program that FIA offers.

A formal assessment will be conducted by an FIA staff person to determine the needs of each customer. Eligibility for most FIA programs that could be of benefit to persons with TBI must be determined in 30-60 days.

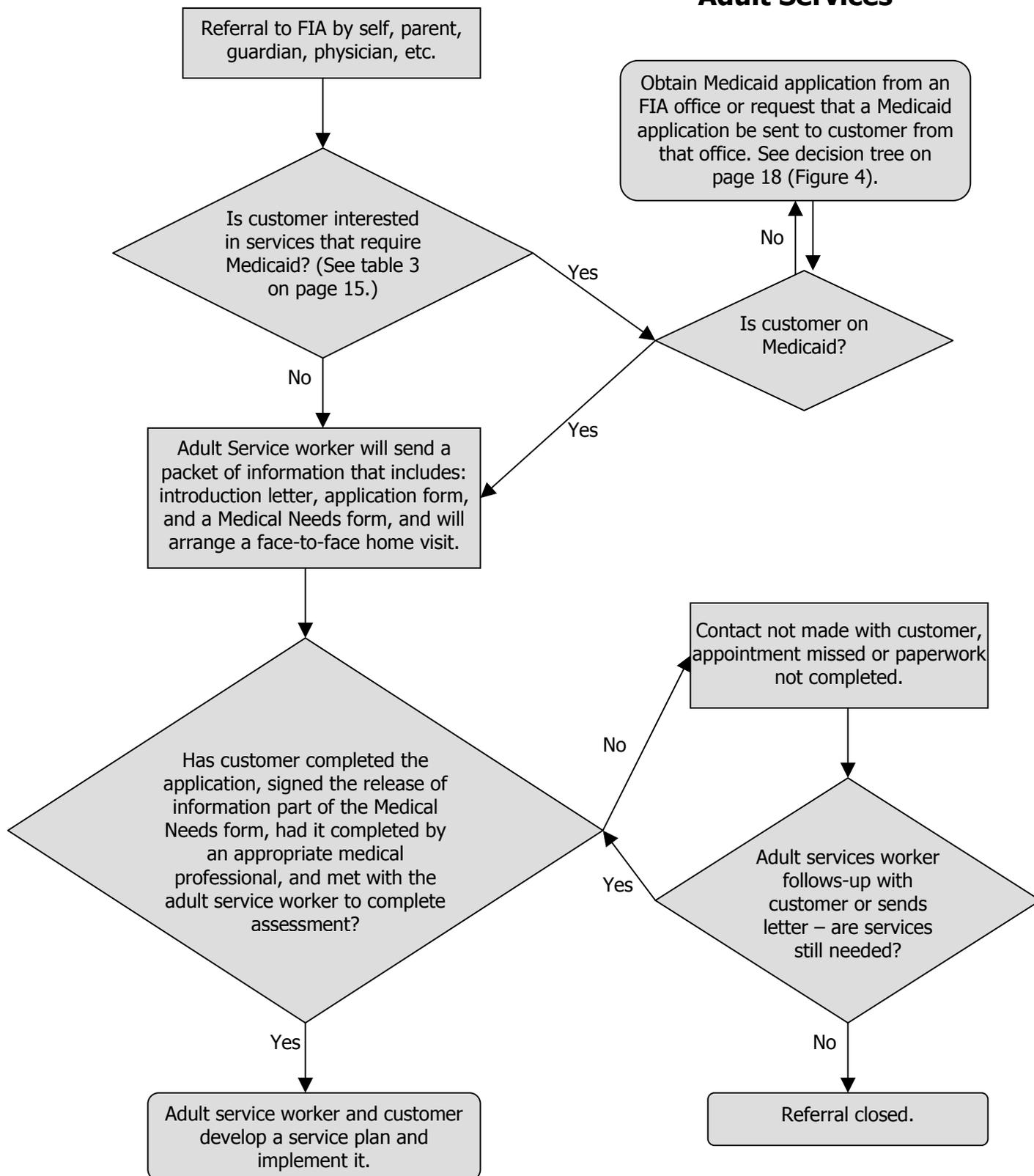
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<sup>5</sup> Includes MI Child and Healthy Kids

**Figure 4: FIA Decision Tree Support for Financial/Healthcare Needs**



**Figure 5: FIA Decision Tree  
Adult Services**



## **How to Appeal a FIA Determination**

Customers may reapply for services anytime they feel their situation has changed to make them eligible. An advocate can be helpful from the point of application to clarify an applicant's wishes and help to obtain necessary eligibility documentation.

Every FIA customer has the right to request a hearing if they feel that services and/or funding were denied or reduced inappropriately. Information on how to request a hearing is part of the official notification letter of denial or reduction.

Hearings involving Medicaid issues are handled by the Administrative Tribunal of the Department of Community Health (DCH). Hearings not involving Medicaid are handled by Administrative Hearings staff in the FIA Bureau of Legal Affairs. There may be multiple levels to the appeals process, including the opportunity for a review of the hearing decision.

**SECTION IV.**

**MICHIGAN DEPARTMENT OF  
COMMUNITY HEALTH -  
LONG TERM CARE PROGRAMS**





## Michigan Department of Community Health (MDCH) – Long Term Care Programs (LTC)

Long Term Care services are not provided directly by MDCH. Rather, Medicaid will provide payment to cooperating agencies or organizations for long-term care services based on the medical need or functional limitations of the consumer. LTC staff can assist with initial information and referral in many cases, but persons seeking specific LTC services should be referred to the contacts listed in the table below.

FIA determines Medicaid eligibility. See pages 15-20 for information on FIA Eligibility Determination services.

**Table 4: Overview of LTC Services**

<b>Long Term Care Services</b>	<b>Eligibility</b>	<b>Contact</b>
<b>Assessment &amp; Rehabilitation of TBI</b>	Must meet medical criteria	MDCH Brain Injury Rehabilitation Program (517) 335-5322
<b>Home and Community Based Services</b>		
▶ Home Health	Medical criteria/Physicians order	Primary Care Physician or Home Health Agency
▶ Home Help	Must have a functional limitation	FIA Office - Adult Services Unit
▶ Physical Disability Services (PDS)	Must meet medical criteria	FIA Office - Adult Services Unit
▶ MI Choice Program	Over 18 & meet nursing facility level of care	MI Choice Program Agent or <a href="http://www.miseniors.net">www.miseniors.net</a>
<b>Residential Services</b>		
▶ Adult Foster Care	Over 18	FIA Office - Adult Services Unit
▶ Homes for the Aged	Over 60	FIA Office - Adult Services Unit
<b>Nursing Facilities</b>	Must need nursing facility level of care	Individual facility or <a href="http://www.michigan.gov/cis">www.michigan.gov/cis</a>
<b>Hospice</b>	Must be near the end of life	Local Hospice agency or <a href="http://www.mihospice.org">www.mihospice.org</a>

# Assessment and Rehabilitation of TBI

## Description of Assessment and Rehabilitation Services

Medicaid covers post-acute, comprehensive, intensive, goal-directed rehabilitation services for persons 18 or older with a brain injury. The specialized program of integrated services is not otherwise available outside of an institutional rehabilitation setting. When the beneficiary presents a documented need for continued specialized rehabilitation services and the complexity of the case indicates the need for a comprehensive, multidisciplinary team approach then services may be authorized in a Medicaid approved residential or outpatient rehabilitation program. This program is usually accessed by a hospital or rehabilitation center on behalf of the beneficiary. Program capacity is dependent upon provider availability.

## Contacting the Office

For additional information regarding the MDCH Brain Injury Rehabilitation Program, call the number listed in the table on page 21 and ask to speak with someone about the TBI Rehabilitation Program. This person will provide details about the criteria that must be met to be eligible for the Program and the steps that must be taken to apply for services.

## Determination of Needs and Eligibility

Needs are assessed by a hospital or a rehabilitation center. Medical records and other personal history documents will be requested to determine needs and eligibility. Eligibility can be determined quickly (2-3 wks) with medical documentation. There is no waiting list, but availability of services may depend on the rehabilitation facility.

### *Financial Eligibility Requirements:*

The beneficiary must be Medicaid eligible as specified by the Family Independence Agency (see page 15). The beneficiaries also must have exhausted all other available resources. If the beneficiary is receiving Supplemental Security Income (SSI), the beneficiary is responsible for room and board payments.

### *Medical Eligibility Requirements:*

Rehabilitation must be medically necessary and ordered by a Michigan licensed physician. The neurological damage must have occurred within the previous 15 months; or a significant, measurable change must have occurred within the past 3 months. (An example of significant change is a change from one Los Amigo Ranchos Scale level to a higher or lower level.) A complete neuropsychological evaluation must be completed within three months of the request for services.

The individual must be medically stable and demonstrate the ability to follow verbal, non-verbal or written directions. The individual must be awake and alert for at least 10 hours a day; bowel and bladder trained, able to perform personal hygiene and grooming with standby cueing assistance and be mobile with or without assistive devices.

For **residential placement**, the individual must be able to participate actively in a minimum of three hours of meaningful, intensive, professional therapy a day or 21 hours per week.

For **outpatient placement**, the individual must be able to actively participate in a minimum of 10 hours of meaningful, intensive, professional therapy per week. If approved, outpatient services are typically available only as an extension of the inpatient Brain Injury Rehabilitation Program for persons with low level continued needs.

## **Home and Community Based Services**

### **Description of Home and Community Based Services**

Home and Community Based Services are provided to enable individuals who need some level of assistance to remain in their home. The need for services may range from help with household chores to nursing facility level of care.

**Home Health** – Skilled nursing care is provided by a registered nurse or home health aid.

**Home Help** – Home Help provides unskilled hands-on personal care such as help preparing meals, eating, grooming, and moving around the home.

**Physical Disability Services (PDS)** – PDS provides assistance purchasing durable medical equipment and home modifications not otherwise covered by Medicaid.

**MI Choice Program** – Support is provided for services and personal care that allow an individual to remain in their home. Some of the covered services include: homemaker and chore services, home-delivered meals, adult day care, modifications to the home, specialized equipment or medical supplies, counseling and respite care.

### **Contacting the Service Provider**

To learn more about Home Health, a consumer should ask their primary care physician, or contact a Home Health agency directly. Eligibility for Home Help and Physical Disability Services is determined through FIA. A consumer can locate their local FIA office in the phone book, or visit [www.michigan.gov/fia](http://www.michigan.gov/fia). MI Choice Program Services are offered through MI Choice Program Agent Offices, which can be located at [www.miseniors.net](http://www.miseniors.net).

### **Determination of Needs and Eligibility**

Once an individual is determined to be Medicaid or Medicare eligible, a formal assessment is conducted by a trained professional to determine the person's individual level of need for Home and Community Based Services. Each program determines eligibility differently.

▶ Home Health – The consumer must meet medical criteria or have a physician's order.

- ▶Home Help Services – Consumers must have a functional limitation in an activity of daily living.
- ▶Physical Disability Services (PDS) – Consumers must have a medical need.
- ▶MI Choice Program – Consumers must be over 18, meet nursing facility level of care criteria and must require one of the thirteen waiver services.

Eligibility determination may take up to 45 days for all Home and Community Based Service. Interim services, pending Medicaid eligibility, are not provided for any of the home and community based programs, except for MI Choice Program. Services for MI Choice Program will be provided if the applicant is potentially Medicaid eligible, but will be terminated if the applicant is not determined to be financially eligible for the MI Choice Program.

Some programs allow beneficiaries to hire family members or friends. Contact the program for more information.

## **Residential Services**

### **Description of Residential Services**

Residential facilities provide supportive services for individuals who need assistance with daily living, such as bathing or medication reminders, but do not need intense medical supervision. Medicaid will pay for services at either a licensed or unlicensed facility for eligible individuals. There are two types of licensed assisted living facilities:

- ▶Adult Foster Care – A living situation where room, board, personal care and supervision for persons over 18 years of age are provided.
- ▶Homes for the Aged – A living situation where room, board, personal care and supervision for persons over 60 years of age are provided.

### **Contacting the Service Provider**

For a list of licensed facilities, visit [www.michigan.gov/cis](http://www.michigan.gov/cis). Services may vary between facilities; a facility should be contacted directly to learn which services are offered.

### **Determination of Needs and Eligibility**

To receive funding for Residential Services, an individual must be Medicaid or SSI eligible. Admission criteria will vary among each assisted living facility.

The following documentation and information may be asked for to determine eligibility: medical condition, demographics, functional ability, medications, support system and other services received.

## **Nursing Facilities**

### **Description of Nursing Facility Services**

A nursing home is a residence that provides housing, meals, nursing and rehabilitative care, medical services, and protective supervision for post acute and long-term needs. It also provides residents with help with daily living and recreational activities. Nursing homes are licensed and most are certified by the State to provide various levels of care, which range from custodial care to skilled nursing care.

### **Contacting the Service Provider**

Nursing Facilities across Michigan offer a range of services. To find a home in a specific area, or a home that provides specialized services, visit [www.michigan.gov/mdch](http://www.michigan.gov/mdch) and click Health Systems & Licensing. The Bureau of Health Systems deals primarily with licensing of health care facilities and related issues in Michigan. When contacting a nursing facility, a consumer should ask to talk to someone from admissions for information regarding the facility, and to request a tour. Search online for websites that will provide guidance on how to select the most appropriate facility. Some examples include: <http://seniors-site.com/nursingm/select.html> or [www.miseniors.net](http://www.miseniors.net).

### **Determination of Needs and Eligibility**

Medicaid will pay for nursing home care for eligible persons. Interim services are provided if a consumer is waiting for Medicaid eligibility determination, but the consumer may be responsible to pay for their stay if Medicaid is not approved.

Eligibility for Medicaid-reimbursed nursing facility care is determined by financial need and medical/functional status. The following documentation and information will be requested to determine eligibility: functional ability, cognitive status, recent medical history and treatments, behavioral issues, and support system and other services received. A nursing home representative may schedule a visit with the applicant and/or family members prior to admission.

As of the printing of these *Guidelines*, policy changes are planned that will affect long term care programs that require nursing facility level of care. Once an individual is determined to be eligible for Medicaid-reimbursed nursing home level of care, nursing facilities will be required to inform applicants of other options for community based care, and provide referral information on such options when requested. If the applicant is admitted to a Medicaid-reimbursed nursing facility, the facility will be required to develop a person-centered care plan that includes goals for discharge.

# Hospice

## **Description of Hospice Services**

Hospice services include skilled care, personal care, pain management, counseling and family support for people at the end of life and their families. Hospice services are typically rendered in the home, but may occasionally be provided in a residential facility.

## **Contacting the Service Provider**

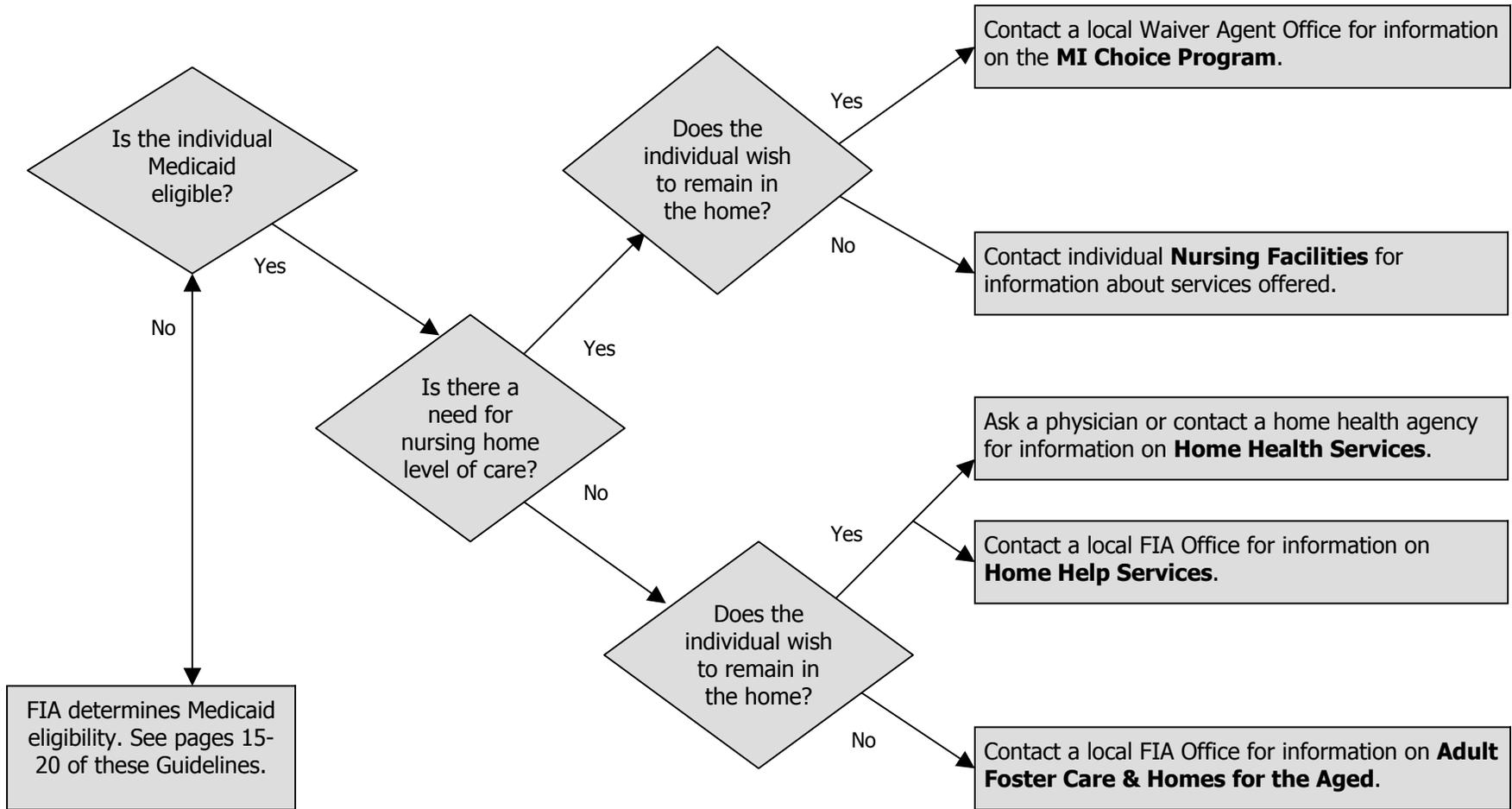
When calling a hospice agency, ask for an intake person. Hospice workers will travel to the consumer's residence.

## **Determination of Needs and Eligibility**

A statement from a physician showing that the person is expected to die within 6 months is necessary to receive hospice services. A formal assessment is done to determine a person's needs.

Eligibility determination and provision of hospice services typically takes place very quickly, and interim services are provided while waiting for eligibility determination. A caseworker will be assigned to the consumer at the beginning of the application process.

**Figure 6: Long Term Care Decision Tree**



## **How to Appeal a LTC Determination**

If a consumer does not agree with his/her eligibility determination, he/she can appeal the decision. Because LTC is not a direct service provider, a denial should be requested from the agency to which application was made. The denial will list the appeals rights for the program in question. Having an advocate is recommended throughout the application process. If a person is deemed ineligible to receive services, a person may reapply for services when his/her situation has changed such that the eligibility criteria will be met.

**For Hospice:** If services are denied, a consumer, or family member on behalf of the consumer, may reapply as soon as they receive the necessary statement from a physician. If a consumer does not agree with a determination, the consumer will need to request a denial and follow the appeals process for Medicare and Medicaid.

**SECTION V.**

**MICHIGAN DEPARTMENT OF EDUCATION –  
OFFICE OF SPECIAL EDUCATION AND EARLY  
INTERVENTION SERVICES**





## Michigan Department of Education – Office of Special Education and Early Intervention Services

**Table 5: Overview of Public Education Services**

<b>Public Education Services</b>	<b>Eligibility</b>	<b>Contact</b>
Special Education for Infants and Toddlers	Age: birth - 2	Local ISD or local public school administrator for special education services
Special Education for Children aged 3-26	Age: 3 - 25	Local ISD or local public school administrator for special education services
Transition Planning	Age: 14 - 25	Local ISD or local public school administrator for special education services

### Description of Public Education Services

**Special Education for Infants and Toddlers** The Individualized Family Service Plan (IFSP) is for infants and toddlers from birth through age two who are experiencing developmental delays and/or who have been diagnosed with a physical or mental condition that may result in developmental delay. The IFSP identifies the supports each infant/toddler and the family is to receive. Some services that might be included are speech and language services, school occupational or physical therapy, orientation and mobility training, an interpreter, assistive technology and consultant services. School professionals may also address hearing, vision, sensory, and behavioral concerns.

Progress of the IFSP is evaluated every six months. Evaluations involve a number of professional school staff working with the child and parents in conjunction with physicians, and community agencies.

**Special Education for Students Aged 3-25** The Individualized Education Program (IEP) is for students with disabilities from age 3 through 25 who have not earned a high school diploma or the equivalent and have been found to be eligible for and in need of a special education program or service. Some of the services might include special education classrooms, speech and language services, school occupational or physical therapy, orientation and mobility training, an interpreter, assistive technology and consultant services. School professionals may also address hearing, vision, sensory, and behavioral concerns.

Progress of the IEP is evaluated at least every year. Evaluations involve a number of professional school staff working with the child and parents in conjunction with physicians, and community agencies.

**Transition Planning** The Individuals with Disabilities Education Act (IDEA) requires transition planning for special education eligible students beginning at age 14. A

Transition Plan arranges an appropriate course of study as students move from adolescence to adulthood. Students can learn academic, vocational and life skills necessary for independent or semi-independent functioning.

## **Contacting the Office**

For information about special education, or to arrange for an evaluation for their child, parents should contact the local Intermediate School District (ISD) office, or the local public school district administrative office, and ask to speak with the administrator responsible for special education services.

Parents have the right to have an interpreter/translator present if their primary language is not English or if the student is deaf/hearing impaired or visually impaired, unless it is clearly not feasible to do so.

Transportation is a special education service decided by the IEP Team. Appropriate special education school staff and others (from other agencies) will service infants and toddlers from birth to age 2, in the home.

## **Determination of Needs and Eligibility**

Students aged birth through 25, who have not graduated from high school may be eligible for special education services.<sup>6</sup> If a student is suspected of having a disability he/she will be assessed after the parents sign the initial consent for the evaluation. The evaluation is conducted by a Multidisciplinary Evaluation Team (MET). Members of the team must include at least 2 persons, one of whom must be a special education teacher or other specialist with knowledge in the area of the child's disability.

The appropriate MET members will complete a diagnostic evaluation and a written report, and will recommend eligibility. The MET uses aptitude and achievement tests, teacher and parent input, educational data, physical condition, social or cultural background, adaptive behavior and other pertinent information that helps to identify the current level of educational performance. Relevant, current documentation or evaluations may be requested to determine needs and eligibility.

After completing the evaluation, the school district must convene an Individualized Education Program Team (IEPT) meeting and must invite the parents to participate. The IEPT determines whether the student is eligible for special education and is in need of special education. If so, the IEPT identifies the specific education the student is to receive, the type and amount of related services, instructional outcomes, goals and objectives, etc. All of this is documented in the IEP. Parents must provide consent the first time an IEP is implemented. For future IEPs, parents must be informed of what the district is proposing for the IEP although, in most circumstances, further consent is not needed.

The school district must determine eligibility within 30 school days after the parent/guardian signs the initial consent. If the student is found to be eligible and has a

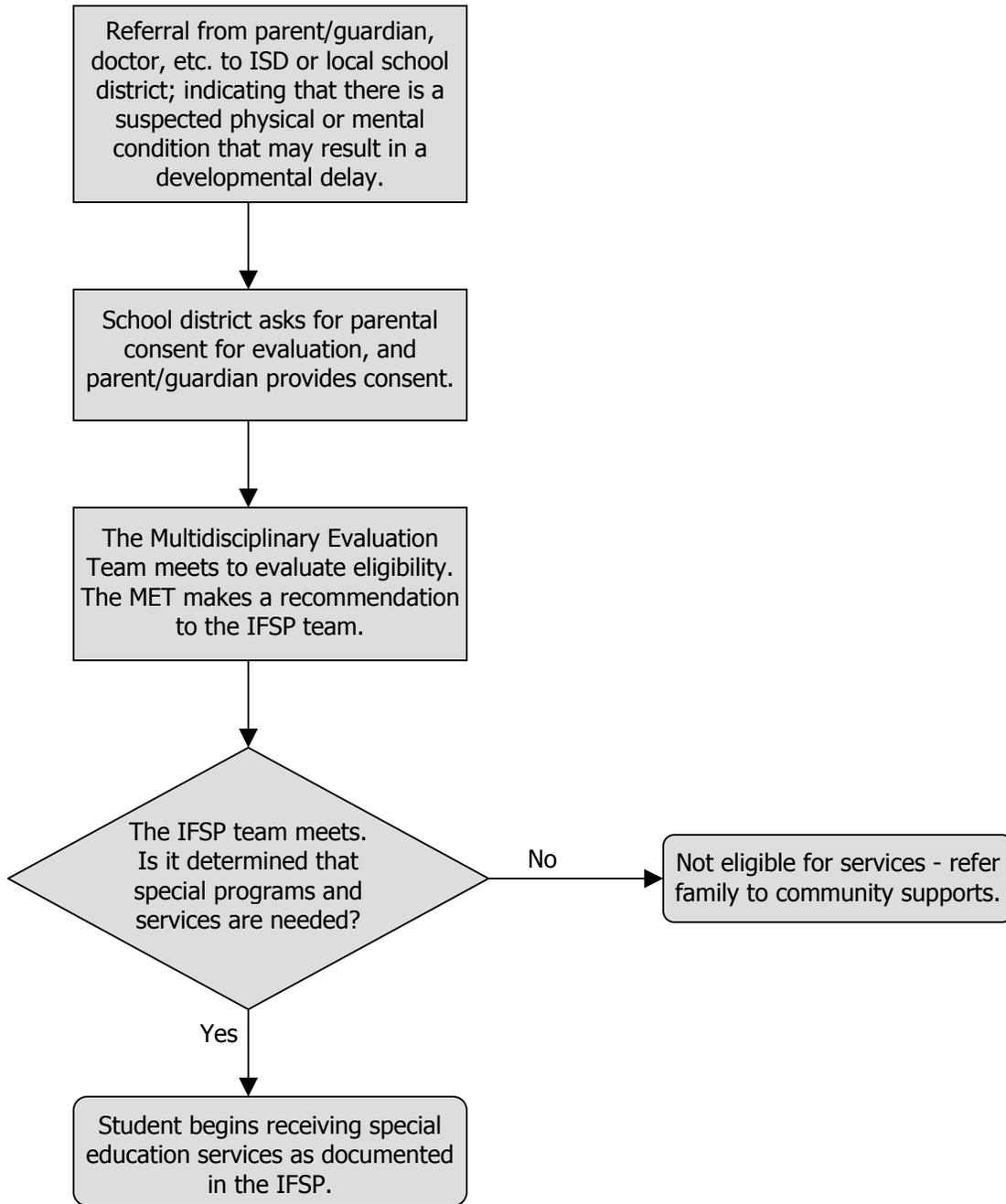
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<sup>6</sup> If a student is 25 at any time during the school year, they may be eligible for special education services.

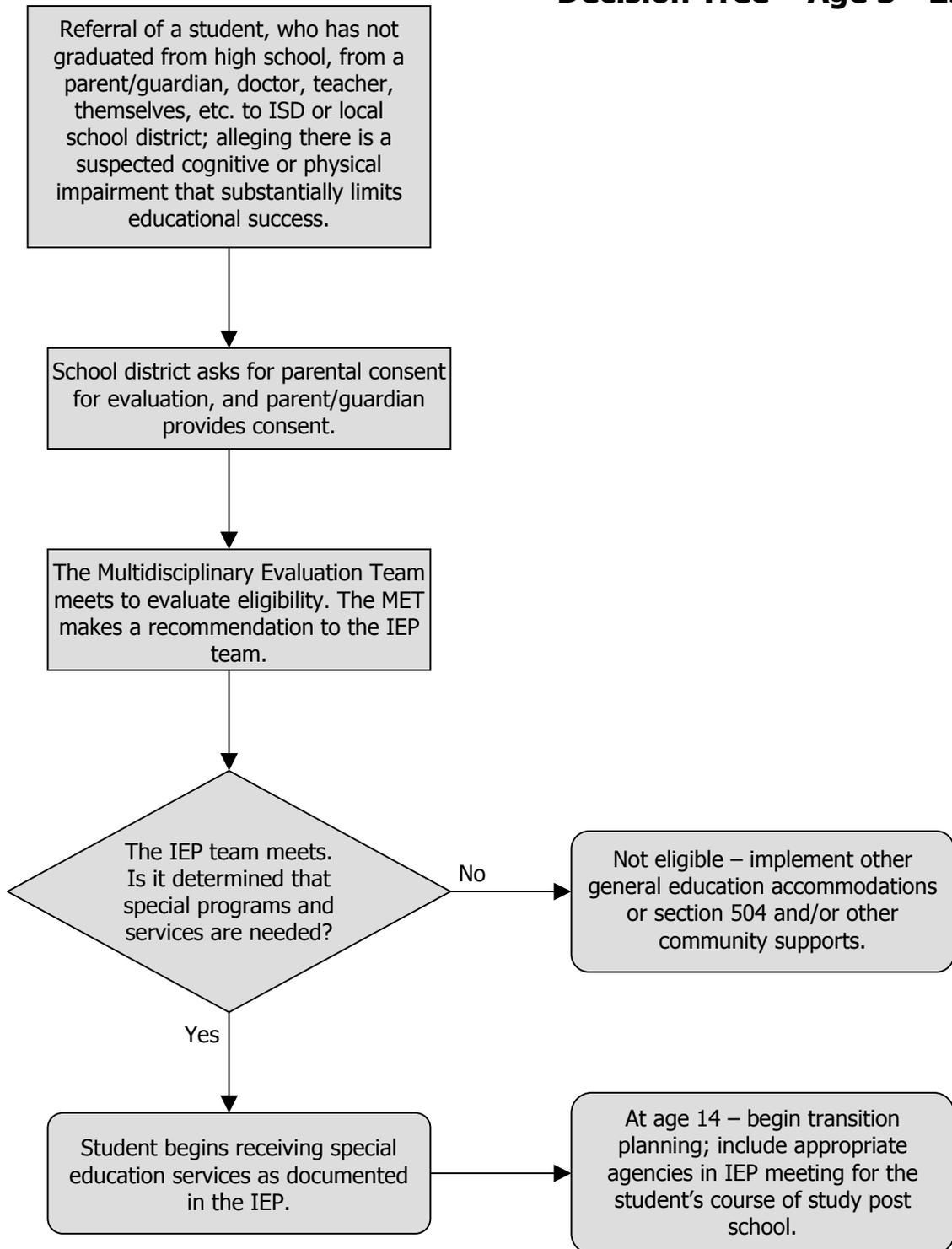
need for services, a special education service provider will be assigned to the student as the service coordinator.

When a student with a disability reaches the age of majority (age 18 in Michigan if a legal guardian has not been appointed by the court), the local school district will provide notice that the parent's rights are transferred to the child.

**Figure 7: Special Education Decision Tree – Infants & Toddlers**



**Figure 8: Special Education Decision Tree – Age 3 - 25**



## **How to Appeal a Public Education Determination**

If parents disagree with a determination, they can ask for an Independent Educational Evaluation through the local school district or through the Intermediate School District at public expense. Parents, at no expense, may ask for mediation or invoke a due process hearing.

Other rights are spelled out in the Procedural Safeguards which is given to the parents at the initial referral for evaluation, annual notification of an individualized education program (IEP) meeting, a re-evaluation (usually held every three years), registration of a due process complaint, or before the date on which the decision to take disciplinary action involving a change in placement might occur.

An educational advocate can be utilized throughout the process at no cost to the parent.

**SECTION VI.**  
**DEPARTMENT OF LABOR & ECONOMIC**  
**GROWTH –**  
**MICHIGAN REHABILITATION SERVICES**





## Michigan Department of Labor & Economic Growth - Michigan Rehabilitation Services (MRS)

**Table 6: Overview of Michigan Rehabilitation Services**

<b>MRS Services</b>	<b>Eligibility</b>	<b>Contact</b>
Assessment	Work related disability	Local MRS office
Employment supports and services	Work related disability	Local MRS office
Training and skill development	Work related disability	Local MRS office
Job placement	Work related disability	Local MRS office
Post employment services	Work related disability	Local MRS office
Disability Management Program	Work related disability	Local MRS office

### **Description of Michigan Rehabilitation Services**

MRS counselors can provide, arrange or purchase for an eligible individual with a disability services related to an individualized plan for employment (IPE) necessary to assist the individual in preparing for, securing, retaining, or regaining an employment outcome in an integrated setting that is consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. (MRS cannot purchase services if another party is legally responsible for them.)

The following services may be provided:

**Assessment** An assessment for determining eligibility, priority for services and vocational rehabilitation needs will be done to determine eligibility and develop an employment goal and an IPE. Assessments may include medical exams, vocational testing, work evaluations, and job try-outs.

**Employment Supports and Services** Employment supports and services might include the following: vocational rehabilitation counseling and guidance; referral services to help secure needed services from other agencies; job coaching; transportation services; diagnosis and treatment of physical and mental impairments; interpreter services for individuals who are deaf; occupational licenses, tools, equipment, and initial stocks and supplies; technical assistance and other consultation services; rehabilitation technology services; transition services that promote movement from school to post-school activities; and supported employment services for individuals with the most significant disabilities.

**Training and Skill Development** Vocational and other training services may be provided including personal and vocational adjustment, books, tools, and other training materials, and such services as are necessary to the adjustment or rehabilitation of the individual. Job seeking skills training is also available.

**Job Placement** Job search and placement assistance as well as job retention services may be provided.

**Post Employment Services** Once the customer is on the job, the counselor follows up for at least 90 days to make sure both the employer and new employee are satisfied. Sometimes additional services are needed. When this happens, MRS can begin working with the customer again to make sure he or she is able to stay on the job.

**The Disability Management Program** The Disability Management Program is a statewide resource for businesses or individuals who need assistance with management of work-related or auto related injuries. This disability management third-party billing service is available to independent and self-insured employers. The purpose is to maximize productivity and minimize costs associated with disabilities in the workplace.

## Contacting the Office

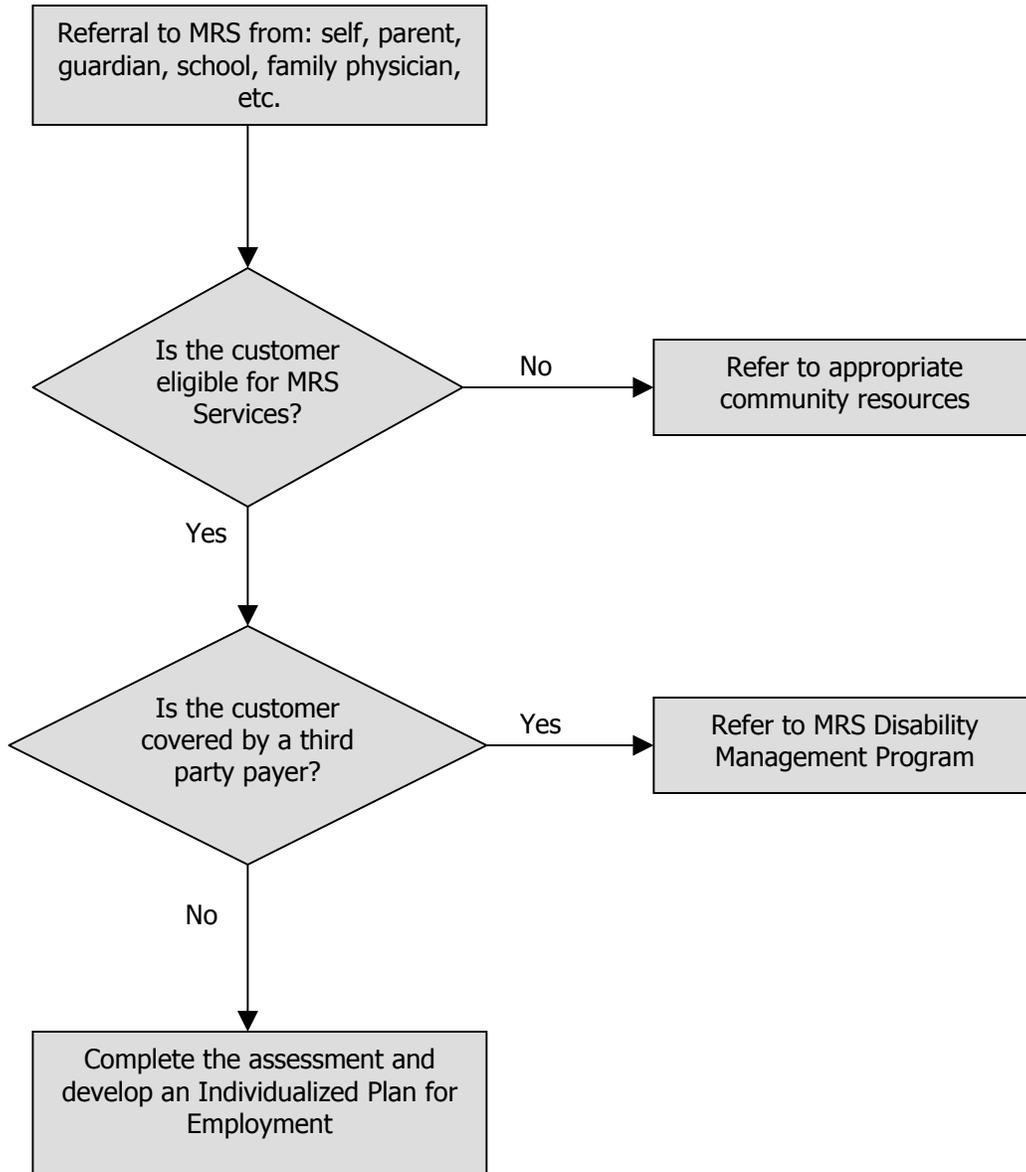
Contact information for local MRS offices can be found at [http://www.michigan.gov/mdcd/0,1607,7-122-1681\\_6362---,00.html](http://www.michigan.gov/mdcd/0,1607,7-122-1681_6362---,00.html). The MRS administrative office toll free number is 1-800-335-4300. TTY is 1-888-605-6722. They will re-direct calls to the local MRS office nearest to the customer. The Disability Management Program can be contacted at 1-877-901-7361. Interpreters are available and translation can be arranged for those with limited English proficiency.

## Determination of Needs and Eligibility

Individuals apply for a determination of eligibility for services at the MRS office nearest their residence. To be eligible, an individual must have a work related disability, require MRS services, want to be gainfully employed and be able to benefit from services to achieve employment.

Persons with TBI may be eligible for services if they have a physical or mental impairment that constitutes or results in a substantial impediment to employment and if they require MRS services to prepare for, secure, retain or regain employment consistent with their ability and capabilities. Persons with TBI who have been determined to have a disability under SSDI (Title II) and/or SSI (Title XVI) program of the Social Security Act are considered to have a significant disability and are presumed to be eligible for MRS services provided they meet the following MRS requirements: they intend to achieve an employment outcome consistent with their unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice; and can benefit from MRS services to become employed.

**Figure 9: Michigan Rehabilitation Services Decision Tree**



## **How to Appeal a MRS Decision**

If an individual disagrees with MRS about a decision related to their rehabilitation program, they can appeal that decision.

First, the person is asked to talk it over with their counselor. An open discussion about the disagreement may help to clarify the situation and make the need for a formal hearing unnecessary. The person (or their representative) can also bring the disagreement to the attention of the site manager for review.

If there is still disagreement with the decision after talking it over with the counselor and the site manager, the person can request a formal hearing. Note: If the person does not feel the informal remedies will help, the person can first request a formal hearing. To request a hearing, a person must write to the MRS state director within 30 days of the date the decision was made. In the letter, the person must state what decision is being challenged, give the name of the MRS office where the person is being served, and ask for a formal hearing.

## Appendix I. – Medicaid Overview

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### MEDICAID OVERVIEW

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#### **AGENCY POLICY    MA Only**

The goal of the Medicaid program is to ensure that essential health care services are made available to those who otherwise could not afford them. Medicaid is also known as Medical Assistance (MA).

#### **SSI-RELATED AND FIP-RELATED**

The Medicaid program is comprised of several sub-programs (i.e., categories). One category is for Family Independence Program (FIP) recipients. Another category is for Supplemental Security Income (SSI) recipients. There are several other categories for persons not receiving FIP or SSI. However, the eligibility factors for their categories are based on (related to) the eligibility factors in either the FIP or SSI program. Therefore, these categories are referred to as either FIP-related or SSI-related.

To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled.

Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories.

#### **GROUP 1 AND GROUP 2**

In general, the terms Group 1 and Group 2 relate to financial eligibility factors. For Group 1, net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. The income limit, which varies by category, is for non-medical needs such as food and shelter. Medical expenses are not used when determining eligibility for FIP-related and SSI-related Group 1 categories.

For Group 2, eligibility is possible even when net income exceeds the income limit. This is because incurred medical expenses are used when determining eligibility for FIP-related and SSI-related Group 2 categories.

## MEDICAID OVERVIEW

MA Category	Unique Non-financial Eligibility Factor	Financial Eligibility Group	Automatic MA Eligibility
<b>FIP-related categories:</b>			
Family Independence Program (FIP)	Family with dependent children	1	Yes
Low-income Family MA	Family with dependent children	1	No
Transitional MA	Family with children	1	Yes
Special N/Support	Family with dependent children	1	Yes*
Title IV-E Recipients	Under age 21	1	Yes
Department Wards	Under age 21	1	Yes
Healthy Kids for Pregnant Women	Pregnant or recently pregnant	1	No
Group 2 Pregnant Women	Pregnant or recently pregnant	2	No
Healthy Kids Under Age 1	Under age 1	1	No
Other Healthy Kids	Under age 19	1	No
Group 2 Persons under Age 21	Under age 21	2	No
Group 2 Caretaker Relatives	Caretaker of dependent child	2	No
Newborns	Newborn	1 or 2	Yes**
<b>SSI-related categories:</b>			
Supplemental Security Income (SSI)	Aged, blind or disabled	1	Yes
Appealing SSI Termination	Appealing SSI termination	1	No
Special Disabled Children	Former SSI recipient child	1	No
503 Individuals	Aged, blind or disabled	1	No
COBRA Widow(er)s	Aged, blind or disabled	1	No
Early Widow(er)s	Blind or disabled	1	No
Disabled Adult Children (DAC)	Aged, blind or disabled	1	No
AD-Care	Aged or disabled	1	No
Extended-Care	Aged, blind or disabled	1	No
Medicare Savings Programs	Medicare Part A	-	No
Group 2 Aged, Blind and Disabled	Aged, blind or disabled	2	No
Qualified Disabled Working Individuals (QDWI)	Type of Medicare	-	No
Home Care Children	Disabled	1	No
Children's Waiver	Disabled	1	No

\* Once established, MA eligibility continues automatically as long as the family remains Michigan residents

\*\* As long as the newborn lives with his mother who is an MA recipient or meets certain MA eligibility factors

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