**Plans for One Instructions:**

Overview:

Regional Behavioral Health Authorities (RBHA) may choose to request funding for a Plan for One (PF1). Plans for One are designed to promote successful transition to and tenure in the community. Prior to the submission of a PF1, all other possible discharge options should be explored, a PF1 should be the last resort. At the discretion of the Director of Behavioral Health or designee, plans may be funded for individuals discharging from, or at risk to admit to Lincoln Regional Center. A PF1 includes services that are designed to meet the individual’s specific needs, such as a non-traditional service or funding for room and board if an individual has applied for benefits and has not yet been determined eligible. Application and submission of a formal PF1 should be a collaborative effort and include the consumer, guardian (if applicable) the discharge entity, receiving entity and regional representative. The required documentation as outlined below must be submitted to the designated Division of Behavioral Health (DBH) staff and approved by the DBH Director or designee.

PF1s are effective from approval until the end of the current fiscal year, after which a new application must be submitted for approval. If seeking funding for the next fiscal year, please submit PF1 application 60 days prior to the start of the new fiscal year.

Please note: Funding for a PF1 is contingent on funding availability within the region. The Emergency System Coordinator is the one who determines if funding can be allocated for a PF1. Collaboration between stakeholders in regards to the clinical needs of the consumer is important in the determination if a PF1 will be sought.

**Process:**

1. The PF1 request will be submitted to DBH Field Rep. Any PF1 request must include the following: 1. An Application for a PF1, 2. A BH-20 Spreadsheet that includes an itemized list of services and costs related to the PF1, and 3. Supporting documentation: (1) LRC Admit date. (1) LRC discharge date, (3) ADL/Safety Needs, (4) Patient’s discharge preference and evidence of role the Guardian and/or individual has played in discharge planning, (5) Goals that are being worked on at LRC (treatment activities while at LRC), and (6) LOCUS most current that would reflect discharging Level of Care (LOC). If a PF1 comes in incomplete, without a BH20, and without supporting documentation, it will not be processed until everything has been submitted.
2. If PF1 application is for Room and Board only, complete Section A and submit along with BH-20.
3. If a PF1 application is for more than Room and Board, both Sections A & B must be completed, submit PF1 application, submit a BH-20, and submit supporting documentation.. Please follow the guidelines listed below when filling out the required fields.
4. The Emergency Coordinator will collaborate with the LRC social worker, or another community entity prior to completion of the application to determine service and funding availibility.
   1. **Summary of Patient Background, history of prior hospitalizations and prior response to treatment:**
      1. Section is completed by the LRC social worker.
      2. Please list all prior hospitalizations including number of admissions and dates of those admissions.
      3. Please briefly address prior services, treatments and consumer’s responses to each.
   2. **Medical and Behavioral Health diagnosis:**
      1. Section is completed by LRC social worker.
      2. Please indicate specific psychiatric diagnosis as per current DSM.
      3. Please include any other relevant medical diagnosis.
   3. **Consumer Needs, preferences, and goals**:
      1. Section completed by LRC social worker.
      2. Please provide a brief description of consumer’s needs, ensuring their preferences and any specific goals that have been discussed or outlined are included and that the consumer’s participation is evident.
   4. **Detailed description of all discharge options that have been explored:**
      1. Section completed by LRC social worker.
      2. Please provide detailed justification for service needs including what services have been explored/attempted and why they can not be an option.
   5. **Detailed description of services to be provided:**
      1. Section completed by LRC social worker.
      2. Please include details regarding what services will be provided to achieve the highest level of independence for the consumer including plans for community integration.
   6. **Outcomes Expected:**
      1. Completed by LRC social worker.
      2. Please include the tools/methods being utilized and the frequency with which data will be collected and documented along with what specific metrics will be used to demonstrate progress.
5. Route the requesting email (including Plans for One application,BH-20, and supporting documentation; see Process #1) to the PASRR program Specialist and Crisis System administrator for approval.

1. Plans for One FAQ:
   1. *When is an individual eligible for a PF1?*
      1. An individual is eligible for a PF1 if they 1. meet DBH eligibility criteria and 2. are either not Medicaid eligible, or they have applied for Medicaid, and are in the process of having their Medicaid benefit turned on.  Additionally, they must be in LRC for 180 days. However, exceptions may be considered on a case by case basis.
      2. PF1 can also be applied for to divert someone from admitting to LRC, who is currently in an inpatient setting.
   2. *What can a PF1 cover?*
      1. A PF1 can cover unique services that need to assist an individual from being discharged from LRC when that service is not necessarily in the DBH service array.
         1. For example, this may look like paying for room and board before an individual’s SSI or Medicaid coverage comes online or paying for a service that DBH (or Medicaid if they are eligible) does not offer.
         2. If the required service is something that already exists in the region’s regularly contracted service array, and the individual is eligible, a plan for one is not needed.
         3. DBH may pay for services that a provider offers that are not a covered benefit through DBH or Medicaid, the provider must still be an enrolled Medicaid provider. If the service is a Medicaid reimbursable service, the provider must be a Medicaid provider.
   3. *What are some examples of things a PF1 cannot cover?*
      1. Services covered by Medicaid when the individual is Medicaid eligible and their Medicaid policy is active.
      2. A Medicaid covered service if Medicaid has already denied that service. For example, If Medicaid is paying for ACT and denying Day Rehabilitation, DBH cannot pay for the denied Day Rehabilitation.
   4. *How long can a PF1 last?* 
      1. A PF1 can last as long as clinically necessary, however the goal of PF1s is to get an individual transitioned into regularly contracted services offered through DBH or Medicaid. On average (though not always) a PF1 should only last a few months to get an individual transitioned into services however extended cases do occur and these will be evaluated on a case by case basis. PF1s extending beyond 6 months will require quarterly status reports.

* 1. *How soon before a discharge can you apply for Medicaid?*
     1. Applications for Medicaid can be accepted when the discharge date is either the month of the application, or the month following the month of application. Medicaid can be turned on the day they discharge.

**PF1s should be approved or denied within 5 business days of receiving a complete application package.**

\*\*\*\*\*\*Note: Regions must contact DBH to make arrangements if they do not begin using the funds within 60 days of the approval.\*\*\*\*\*\*\*