[ADD LETTER HEAD]

# INTER-COUNTY PLACEMENT AGREEMENT

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| Placing County: |  |
| County Designee: |  |
| Phone Number: |  |
| Receiving County: |  |
| County Designee: |  |
| Phone Number: |  |
| MCO Agency: |  |

Date of Admission by Placing County/Agency:

This agreement pertains to (individual): DOB:

Last Known County Address:

This agreement confirms the financial responsibility of Placing County/Agency for the care and ongoing planning for the above-named individual and Placing County/Agency confirms the above-named individual is a resident of Placing County immediately prior to placement.

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| 1) | The above-named individual is placed at the following facility: |
|  | Facility Name: |
|  | Facility Address: |
|  | Facility Phone Number: |

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| 2) | The individual’s legal status is: Voluntary or Protective Placement (Ch. 55)  and/or Civil Commitment Order (Ch. 51). |

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| 3) | Legal Guardian: | Yes (complete below) No |
|  | Activated Power of Attorney: | Yes (complete below) No |
|  | Name: |  |
|  | Address: |  |
|  | Phone Number: |  |

4) The facility is a (check one): Child Family Foster Home

Community Based Residential Facility

Other

Adult Family Home Skilled Nursing Facility

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| 5) | The Placing County primary contact is: |
|  | Contact Name: |
|  | Contact Address: |
|  | Contact Phone Number: |
|  | Contact Role: |
|  | After Hours Phone Number: |

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| 6) | Is a Managed Care Organization (MCO) involved? | Yes (complete below)  No |
|  | Name of MCO: |  |
|  | Care Manager’s Name: |  |
|  | Phone Number: |  |

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| 7) | Cost of care payable to the facility will be paid by (check all that apply): |
|  | Self-pay Placing County Insurance MCO  Other |

Paragraphs 8 through 11 only apply if Self-Pay is not the method of payment checked in Number 7 above.

1. At any time during the duration of this agreement, both counties agree to utilize and abide by the State Department of Health and Family Services Manual (as set forth in DDES Numbered Memo Series 2007-01, and as supplemented by DLTC Numbered Memo 2011-08) as it relates to a determination of residency and payment for services by the county responsible to provide those services.
2. Services not available by placement facility and deemed clinically appropriate by both the Placing County and Receiving County shall be the financial responsibility of the county of residence, to the extent the cost of service is not covered by Medicaid or other third-party insurance.
3. If acute psychiatric services are needed, the facility designated to provide these services is .The contact name is . The contact number of the designated facility is . The Placing County will be responsible for the cost of transportation and cost of transportation and cost of inpatient psychiatric treatment. When possible, the Placing County will be consulted in advance of transfer and admission to psychiatric, but will be responsible for the cost as a payer of last resort, after insurances and self-pay has been applied.
4. Placing County will not be responsible for medical treatment and transportation unless preauthorized by the Placing County, except when such treatment and services are required on an emergency basis. Placing County shall remain payor of last resort.

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| 12) | Any dispute(s) regarding this Agreement shall not be subject to the initiation of legal action until Placing County/Agency and Receiving County have made reasonable and good-faith efforts to resolve the dispute(s). Such good-faith  efforts must include direct discussions of potential dispute resolution between the County Designees of Placing County/Agency and Receiving County. |

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| 13) | This agreement shall be in effect for three (3) years from the date of executed agreement by Placing County, until client is discharged from placement, or a change in funding or circumstance, whichever comes first, unless modified by written consent of all parties. |
| 14) | This Inter-County Placement Agreement, or any part thereof, must be amended or terminated in the event of any of the following that affect the financial status of the Placing County or the Receiving County:   1. Change in Medicaid or Medicare rates 2. Changes required by Federal or State laws, regulation, rules, and polices 3. Administrative Agency or Court action that negatively impacts either County 4. Change in available funding to either County |

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| 15) | A copy or facsimile of this document shall be valid as original. |

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| Authorized Placing  County Representative |  |  |
| Signature |  | Date |
| Printed Name |  |  |
| Authorized Receiving County Representative |  |  |
| Signature |  | Date |
| Printed Name |  |  |