WISCONSIN DEPARTMENT of HEALTH SERVICES

Checklist for Managed Care Organizations in the Chapter 50 Resident Relocation Process

Background

This checklist offers guidance to interdisciplinary teams who are supporting members residing in nursing homes, intermediate care facilities for individuals with intellectual disabilities (ICF-IID), and community-based residential facilities (CBRF) that are relocating residents under the requirements of Wis. Stat. Chapter 50.

The intent of Wis. Stat. Ch. 50.03(5m) and (14) is to promote the safe and orderly transfer of residents in a way that diminishes the possible effects of relocation stress syndrome (RSS), also known as "transfer trauma."

Resident rights—relocation process

These rights are defined in Wis. Stat. Ch. 50.03(5m) with the purpose of mitigating RSS:

- Right to adequate care and treatment in the least restrictive and most integrated setting.
- Right to be provided with an opportunity for at least three visits to potential alternate placements before relocation.
- Right to be informed and receive adequate notification of discharge decisions.
- Right to reasonable accommodations of needs and preferences.

Timelines and relocation plan submission

Wis. Stat. Ch. 50 relocation plan requirements apply when:

- The facility intends to close, change the means of reimbursement accepted, or change the type or level of services provided.
- The facility intends to involuntarily discharge at least five residents or 5% of the residents, whichever is greater.

After the Department of Health Services (DHS) approves a facility's resident relocation plan:

- The facility will choose a target date to close or make an approved change that is:
  - No earlier than 90 days from the date a relocation plan is approved if five to 50 residents will be relocated.
  - No earlier than 120 days from the date a relocation plan is approved if more than 50 residents will be relocated.
- Formal notification of the closing or approved change will be provided to impacted organizations, including managed care organizations (MCOs) and aging and disability resource centers.
- The resident relocation process begins.

Find more information about the Chapter 50 resident relocation process and the residential provider's responsibilities in the Resident Relocation Manual, P-01440, (dhs.wi.gov/publications/p01440.pdf) or on the DHS Relocation webpage (dhs.wi.gov/relocation).

MCO role in the resident relocation process

Step	Action	Date Completed
1	Participate in the DHS-led orientation meeting.	
2	Participate in the initial planning conference with the facility, member, legal decision-maker, and anyone the member requests to participate. • Review the need for relocation from the facility. • Determine resident preferences (for example, location, size, type, and accommodations available). • Assess for RSS (initial assessment and ongoing through adjustment to the new setting). • Determine who will make referrals (if not the MCO). • Develop an individualized relocation plan with activities to help the member plan their transfer from the facility.	
3	Make referrals that the member agrees to. • Inform the facility and the member or their legal decision-maker about every referral. • Update the DHS-led relocation team on referral progress.	
4	Ensure in-person assessments are arranged at times the member agrees to, and provide necessary paperwork.	
5	If a provider accepts, assist with arranging 1–3 tours for the member or their legal decision maker according to their preferences and individualized relocation plan. If the member does not wish to tour, ensure the individualized relocation plan outlines how they would like to be prepared for the move.	
6	Confirm if the member agrees to the placement. • If they decline, begin the referral process again. • If they agree, schedule a discharge planning conference.	

Step	Action	Date Completed
7	Participate in the discharge planning conference with the facility, member, legal decision maker, receiving home, and anyone the member requests to participate. • Discuss available assistance to move the resident, belongings, and personal funds. • Set a move date according to the member's preference. • Determine who will help pack and unpack. • Determine how the member will be transported and who will support them the day of the move. • Finalize any changes to providers, pharmacy, durable medical equipment and supplies, etc. • Determine who will complete the change of address with USPS. • If the member is under guardianship, determine who will notify the court of the change of address. • If the member is moving to a county that is not the county of responsibility and meets criteria, complete and send the Family Care Member County Notification, F-02558 (dhs.wi.gov/forms/f02558.docx) to the new county of residence. • If the resident is under a protective placement order, determine who will submit the Notice of Transfer of Protective Placement, GN-4340.[1] *__Note__: Timing of submission must allow a 10-day notice before admission to the receiving home. • Important: Review roles and responsibilities of guardians, MCOs, and adult protective services in this document from the Guardianship Support Center (gwaar.org/api/cms/viewFile/id/2004355).	
8	Call the receiving home, member, and/or their legal decision-maker on the date of transfer to determine if the move was successful.	
9	Complete an in-person visit with the member shortly after relocation. • Assess for symptoms of RSS. • Ensure the member has all their belongings. • Assess for satisfaction or concerns and follow up.	

[1] wicourts.gov/formdisplay/GN-4340.pdf?formNumber=GN-4340&formType=Form&formatId=2&language=en

Step	Action	Date Completed
	• Ensure receiving home has all necessary durable medical equipment and supplies, prescription, and orders. • Update the DHS-led relocation team after the post-move visit.	