

Referral Guidance for Case Managers

New: Aug. 4, 2026

Starting the Guardian Trac (GT) referral process

For Long-Term Care Support Services (LTCSS), the case manager (CM) starts the GT referral process by submitting the CA/PS Assessment Summary SDS 002N form. For State Plan Personal Care (SPPC), the CM starts the referral process by submitting a SPPC Service Plan and Task List SDS 546PC form.

The service plan does not need to be approved in Oregon ACCESS (OA) at the time of the referral. The referral is not an authorization to begin services.

When completing the 546PC, fill out the first section on page one and the “Tasks to Be Completed” section. A signature is not required. Client Representative contact information should also be included when applicable.

Individuals may still be comparing options

If an individual is interested in Agency with Choice (AwC) but is still comparing in-home service options, the CM may provide information for available in-home agencies, including GT. The individual may contact GT to ask questions and learn more about AwC before deciding.

A CM may choose to contact GT before sending a referral

CMs may contact GT before or after submitting a referral to share information that could support enrollment planning. This may include details about the

individual's needs, preferences, current circumstances, available backup support, or specialized training needs.

Additional communication may be especially helpful when the individual has complex support needs or when there are questions about whether available support can safely meet those needs.

Transition planning may be needed

If the individual is moving from Consumer-Employed Provider (CEP), an in-home care agency (IHCA), or another support arrangement to AwC, the CM should not end or change the current service arrangement until the transition plan is clear, a start date is identified, and GT confirms services are ready to begin.

Individuals transitioning from CEP to AwC who want the same Homecare Worker (HCW) provider

If an individual is transitioning from CEP to AwC and wants to continue working with the same support provider, the HCW must apply with GT and complete any required steps in GT's DSW enrollment process before providing services through AwC. GT will review the HCW's current provider status and determine what enrollment steps are still needed.

The CM can begin the referral once the individual decides to move forward with AwC, even if the HCW is still completing GT's hiring process. Current services should remain in place until GT confirms that enrollment is complete, the DSW is approved to begin work, and an AwC start date has been established.

Scenarios

- **Individual wants to compare in-home service options**

Remi is currently using the CEP option but is unsure if it is still the right option for Them. They want to learn more about other in-home service options.

The CM reviews available in-home options with Remi, including traditional IHCA and AwC. Remi is unsure and wants more information about the difference between a traditional IHCA and AwC.

The CM provides Remi with contact information for available IHCAs in the area, including GT Independence, the AwC provider. If Remi chooses AwC, the CM starts the GT referral process by sending the 002N CA/PS Assessment Summary Form and Client Representative contact information, if applicable.

- **Individuals may need additional planning before services begin**

Remi is interested in AwC, but their situation may require additional planning before services can begin. The HCW recently quit, creating a possible service gap, and they have had difficulty keeping support in place. Other planning needs could include complex health or behavioral supports, specialized DSW training, limited backup support, or concerns about whether available supports can safely meet their needs.

The CM reviews the available in-home service options with Remi and confirms that they are interested in AwC.

Before or when sending the referral, the CM may contact GT to share information about Remi's current situation, needs, preferences, and any

immediate concerns. GT can use this information to determine whether additional planning is needed during enrollment.

The CM starts the GT referral process by sending the 002N CA/PS Assessment Summary Form and Client Representative contact information, if applicable.

- **Individual needs flexible scheduling and more than one DSW**

The following scenario shows how additional planning may happen during enrollment after the referral information is received by GT.

Remi chooses AwC because they need support at different times of the day and wants flexibility in how the approved hours are scheduled.

Remi needs a short shift in the morning, a longer shift in the middle of the day, another short shift in the evening, and occasional support for a short period during the night. Remi may need more than one DSW to meet this schedule.

The CM starts the GT referral process by sending the 002N and Client Representative contact information, if applicable.

During enrollment, GT can help Remi plan how many DSWs may be needed and identify DSWs who might be able to meet the scheduling needs. GT can also support Remi in planning how to explain their schedule to potential DSWs.

Additional support from GT can include helping Remi search the DSW registry, prepare interview questions, discuss availability and backup options, and clearly describe his scheduling needs.

GT does not set Remi's schedule. Remi is responsible for scheduling DSWs within the hours approved in the service plan. AwC does not require a minimum

shift length and does not limit the number of DSWs who may support the individual, as long as services are provided within the authorized hours and service plan requirements.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Aging and People with Disabilities at apd.ltss@odhs.oregon.gov or 503-945-5600. We accept all relay calls.



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