Aging and People with Disabilities
Agency with Choice

OREGON DEPARTMENT OF Human Services
Aging and People with Disabilities

ODHS APD – Agency with Choice (AwC) Referral Process for Case Managers

Referral process

1. Present in-home service options

Case Managers (CMs) meet with the individual to review APD service options and explain the available in-home care models.

The CM explains the Agency with Choice (AwC) program and confirms the individual's interest.

Note: AwC is currently available only to individuals eligible for one of the following benefit plans:

•APD

•KPS

•BPA

•BPO

2. Individual chooses AwC

If the individual elects to participate in AwC, the CM proceeds with the referral steps.

3. Submit referral to GT (AwC provider)

The CM sends a referral to GT including (for all Individual on Title XIX):

•002N CA/PS Assessment Summary Form

•Client representative name and contact information (If the individual has identified a client representative on the 737 form)

The CM sends a referral to GT including (for all individuals on SPPC)

•546PC Form (only individual information and the task list needs to be filled out)

•Client representative name and contact information (If the individual has identified a client representative on the 737 form)

Important: Before sending any email that includes Individual information, add “secure# to the subject line to ensure it is sent securely.

GT Contact information (email must be secure):

Email: customerservice@gtindependence.com

Phone: 1-877-659-4500

4. GT outreach to individual

After receiving the referral, GT will:

•Contact the individual and/or client representative within five business days

•GT will make up to three attempts to schedule an initial meeting

•If unable to contact the individual/or client representative, GT will notify the CM

5. Initial meeting with GT

During the initial meeting, GT will:

•Complete an assessment to identify the individual's needs and preferences

•Determine whether the Individual already has a potential Direct Support Worker (DSW) in mind

•If not, assist the individual with Identifying or recruiting a DSW

•Explain the co-employer role and the support GT provides

•Gather the individual's preferences and scheduling needs

•Assist in developing a back-up plan for planned or unplanned caregiver absences

6. DSW identification and enrollment

If the individual has a potential DSW:

•GT works with the potential DSW to complete the GT enrollment process, including background checks, orientation, and required training.

If the individual does not have a potential DSW:

•GT helps match the individual with an available GT-enrolled DSW or assists with recruitment based on the individual's needs and preferences

If GT determines that it cannot accept the individual for AwC services:

•GT notifies the individual and the CM in writing, including a brief explanation of the reason and any alternative steps or resources available.

•If GT does not have an available DSW and recruitment efforts are unsuccessful, GT informs the individual and the CM and provides updates

on ongoing recruitment efforts. GT collaborates with the CM to identify next steps or alternative service options based on the individual's needs and preferences.

•If the individual changes their mind at any point during DSW identification or enrollment, GT communicates this change promptly to the CM. GT documents the individual's decision and discusses available options with the individual, including pausing the process, restarting enrollment at a later time, or exploring other service arrangements.

7. Service start date and authorization

Once a DSW who has met all GT enrollment requirements is identified, GT will:

•Communicate the service start date to the CM

The CM will then (for all individuals on Title XIX):

•Authorize GT in the Individual's service plan

•Follow local office procedures to create a Plan of Care in MMIS

•Send the 546 In-Home Service Plan to GT.

The CM will then (for all individuals on SPPC):

•Authorize GT in the individual's service plan

•Follow local office procedures to create a Plan of Care in MMIS

•Send the completed 546PC In-Home Service Plan to GT

Note: Both ADL and IADL hours may be authorized under the ADL: PC – T1019 procedure code. Local offices do not need to create separate line items for ADL and IADL hours

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.

OREGON DEPARTMENT OF
Human Services

Aging and People with Disabilities
Medicaid Services and Supports 500
Summer St. NE, E-10
Salem, OR 97301-1076
503-945-5600
odhs.info@odhs.oregon.gov
www.oregon.gov/odhs