

HOME Choice

Pre-Transition Case Management Provider Manual



Helping Ohioans Move, Expanding Choice Ohio's Money
Follows the Person Demonstration Project
CFDS #93.791

Ohio Department of Medicaid
3/2016

Welcome to your HOME Choice Service Provider Manual

We are grateful to have you working with us in assisting individuals to be successful and sustainable in the community. For some, this is their first opportunity after many years, to live independently, with family or friends and be in and of their community. What a major life event! And you get to share this part of their life journey. How amazing and powerful!

We value the work that you do and hope this manual will guide you through your HOME Choice experience as a provider and will serve as a resource and reference going forward. Never hesitate to contact our office with your questions as we are here for you and with you as a part of the HOME Choice Team. There are lots of "players" but one collective goal: To assist individuals to be as successful as possible.

It won't always be "easy", but remember you are a part of a team and as a team:

T – Together

E – Everyone

A – Accomplishes

M - More

Be passionate about people's lives and their hopes and dreams. Be open to learning and growing. See the opportunities amidst the challenges. Remember to breathe. And keep in mind...

"The People Who Are Crazy Enough To Think They Can Change the World, Are the Ones Who Do" -Steve Jobs

Thank you for all that you do! We are changing the world together, one person at a time.

Jane Black

MFP Project Director for Ohio

TABLE OF CONTENTS

Welcome from the MFP Project Director

Introduction	4
Who's Who in the HOME Choice Program	5
Discharge Planning & Transition Team Overview	6
PTCM Provider Flow Chart	7
Initial HOME Choice Process & PTCM Roles & Responsibilities	8
Ongoing PTCM Responsibilities	9
PTCM Responsibilities at Time of Discharge	10
HOME Choice PTCM Forms and	11
Resources	17
A. HOME Choice Operations Contact Information.....	18
B. HOME Choice Roles and Responsibilities (PTCM, TC, HCCM).....	20
C. Forms & Tools.....	22
D. Change In Status Form.....	23
E. HOME Choice Website Information.....	25
F. Training Updates and Resources.....	26
G. HOME Choice Pre-Transition Case Management Provider Agreement	27

Introduction

“Money Follows the Person” (MFP) is a federal program/grant established under the Deficit Reduction Act of 2005 and was expanded under the American Care Act of 2010. The state of Ohio’s MFP program is officially known as

“HOME Choice” with each letter representing the purpose: Helping Ohioans Move, Expanding Choice.” In 2008, Ohio was a recipient of this grant and implemented the transition program in the fall of that year.

Our Vision:

Ohioans who need long-term services and support will get the services and supports they need in a timely and cost effective manner, in settings they want, from whom they want, and if needs change, services and supports change accordingly.

Our Mission:

To transition individuals from institutions who want to live in the community and create balance to long-term services and support system to a person-centered, needs-based system that offers choice of where individuals live and receive high-quality services and supports.

HOME Choice is about:

- A comprehensive strategy to address long term services and supports to all Ohioans in need.
- The system adapting to the person, not the person adapting to the system.
- Working with all populations including: the elderly, people with disabilities, people with mental health diagnoses, substance use disorders, developmental disabilities, infants in children's hospitals, and youth/teenagers in residential treatment facilities.

HOME Choice is not a waiver program and the services available through this transition program are funded through the grant, not Medicaid.

HOME Choice Eligibility Criteria for Individuals:

- Medicaid eligible
- Have lived in a Medicaid facility for at least 90 days at the time of discharge
- Have care needs evaluated by HOME Choice staff, and
- Move into qualified housing

The purpose of this manual is to provide the tools, resources and expectations for HOME Choice Pre-Transition Case Management Providers that will enable and empower you to provide value added services to Ohioans. Thank you for sharing the journey. Together, we are Making Ohio Better!

WHO'S WHO IN THE HOME CHOICE PROGRAM

Below is a list of team members Pre-Transition Case Managers collaborate with to transition HOME Choice participants into community.

HOME Choice Operations: Ohio Department of Medicaid's administrative entity that manages the HOME Choice Program.

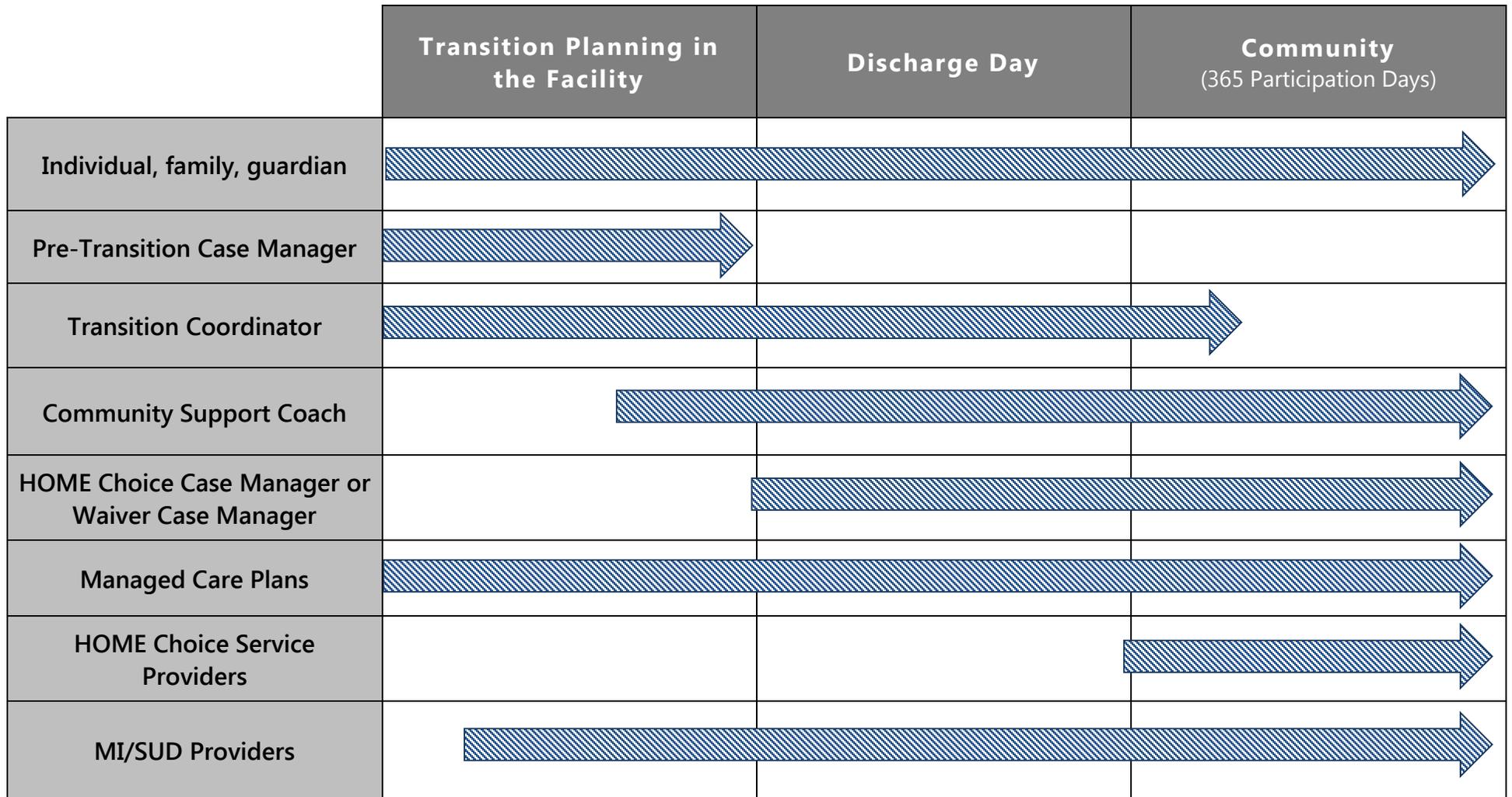
- **Intake Staff:** Applications, documents, forms and communication are submitted to the HOME Choice Mailbox HOME_Choice@medicaid.ohio.gov or by fax 614-466-6945. Intake staff processes documents, makes referrals and forwards forms and information to CLA's.
- **Community Living Administrator (CLA):** Responsible for a specific population of HOME Choice participants (Please refer to the HOME Choice Contact List for a detailed breakdown of all staff). Questions regarding a specific case should be addressed with the appropriate CLA.
- **Provider Administrator:** Responsible for provider communications, provides technical assistance and education, coordinates the semi-annual HOME Choice training sessions, responsible for HOME Choice rule development and is responsible for all provider billing/payment issues.
- **Provider Oversight and Compliance Manager:** Reviews incident reports for non-waiver HC participants; addresses provider compliance issues; serves as the HOME Choice program liaison, subject matter expert and trainer for MyCare Ohio, and Medicaid Managed Care Plans. Works closely with the Provider Administrator with provider training and other issues.
- **Administrative Assistant:** Processes provider applications and responds to questions regarding their status; updates provider contact information.

HOME Choice Provider Types:

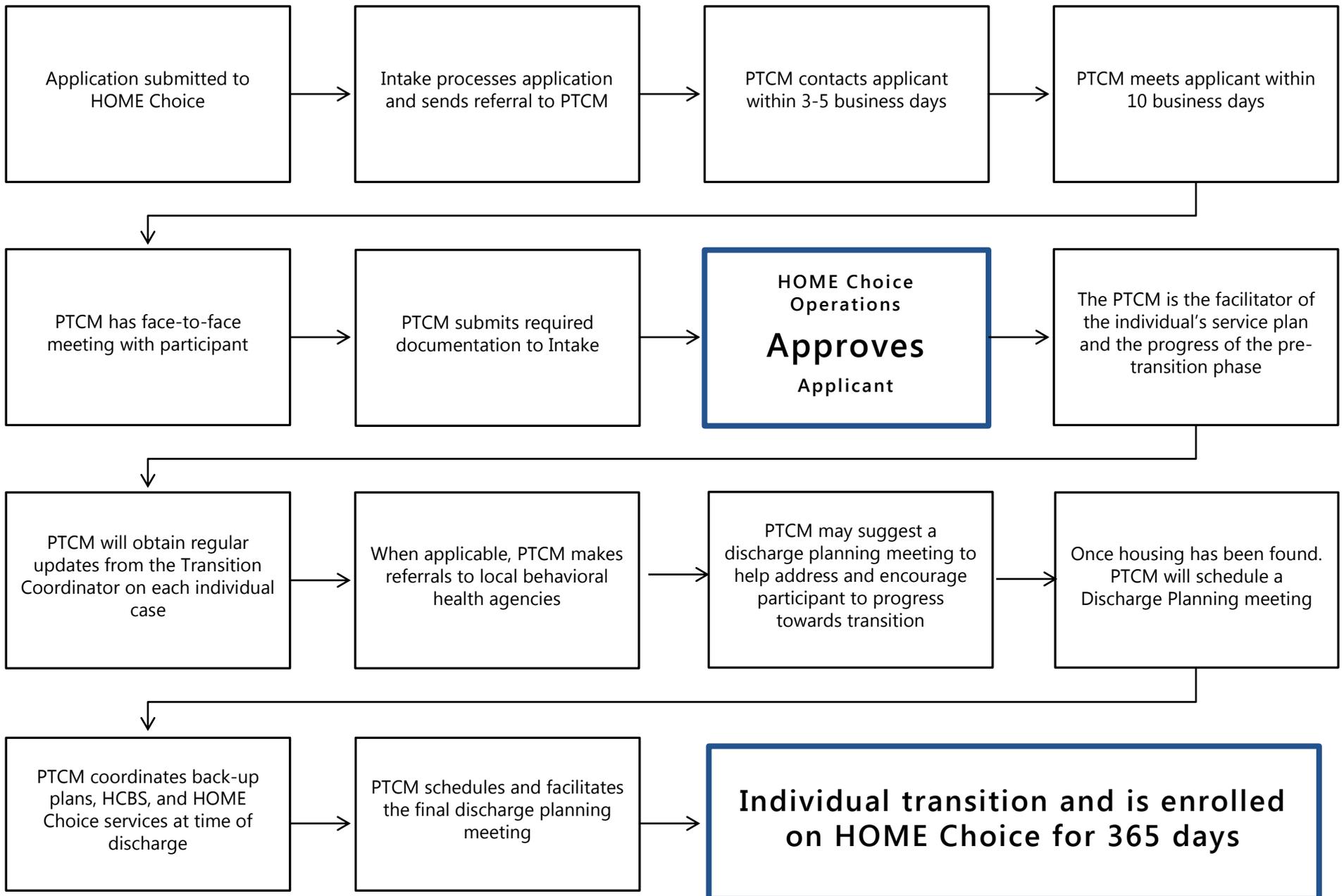
- **Pre-Transition Case Manager (PTCM):** Most HOME Choice participants are assigned a PTCM to oversee the pre-transition phase of the individual's transition into the community. The PTCM is responsible for coordinating the flow of information to members of the transition team and for the on-going monitoring of the participant's discharge status. Individuals with developmental disabilities, infants, kids and youth have a different PTCM process.
- **Transition Coordinator (TC):** The TC is responsible for providing pre-transition services which may include housing assistance, coordination of benefits, establishing budgets and many other activities to assist participants with their discharge from an institutional setting. The TC assists the participant with pre-discharge planning, the discharge process and their transition to the community and for 90 days after discharge.
- **HOME Choice Case Manager (HCCM):** All participants receive case management for the 365 days they are enrolled. Participants not on a waiver receive community case management from a HOME Choice Case Manager. The HCCM is responsible for ensuring the participant has the services necessary to be sustainable in the community. Necessary services may include: Additional HOME Choice services, home health and medical services, behavioral health services, community resources and other services to meet the needs of the individual. The HCCM is the primary point of contact for service providers and medical professionals regarding the individual's community status.

Discharge Planning & Transition Team Overview

The chart below represents a high level overview of when providers start participating in the discharge and transition process for an individual. It demonstrates the need for communication and collaboration among all members of the team, including the individual and their support network. There are a lot of players, but there is one collective goal: to assist an individual to be as successful as possible throughout the transition process and while in the community. It is important that the Team work together to identify goals, outcomes and timelines for transition and if needs change, services and supports change accordingly.



Pre-Transition Case Management Flow Chart



Initial Face-to-Face Meeting PTCM Responsibilities

1. A person applies to HOME Choice:

Upon receiving the application, intake will process the application and send authorization to the appropriate PTCM agency to initiate the face-to-face assessment. An "application report" is sent to the PTCM provider agency as an attachment with the list of referrals

2. PTCM contacts individual/facility:

PTCM makes the initial contact (phone) with the individual within 3-5 business days

3. Responsibilities before face-to-face meeting:

- review the application prior to making contact with the individual or the facility
- **If the individual declines assessment or is no longer at the facility, submit the eligibility checklist with the outcome of contact documented.**
- PTCM must submit the Eligibility Checklist when not recommending HOME Choice for an individual.

4. Face to Face Assessment:

When you meet with the individual, please provide copies of forms for the individual (and others if applicable) to review during your time together. The following items must be completed during the initial meeting:

- Informed Consent
- Eligibility Checklist (See #3 above if person declines participation or you are not recommending them for HOME Choice.)
- Community Readiness Tool
- ODM Form 2399 (If recommending waiver assist the individual in applying for services)
- Selection of the Transition Coordinator Agency & Service Plan

Goods & Services Funds

Information about HOME Choice is often shared among individuals residing in facilities. Information about startup (goods & services) funds is often misconstrued. Refer to the Informed Consent form when describing this service. It is best to have the individual discuss this further with the transition coordinator. Below is general information on the Community Transition funds (Goods & Services):

- All funds are channeled through the Transition Coordinator agency.
- No individual receives funds directly.
- Once an individual moves into community, the Transition Coordinator and Case Manager are responsible for all inquiries regarding additional purchases. Funds are not necessarily available throughout the 365 days of enrollment.
- The Case Manager, Transition Coordinator and service providers must explore all community-based charitable resources before requesting the use of any funds, post discharge.
- All requests are subject to the approval of HOME Choice Operations.

5. Submit the completed documents to HOME Choice:

Once you have finished the assessment, please submit the forms to HOME Choice Operations for processing. Once processed by HOME Choice, you will receive notification when the individual has been approved to participate and the transition coordinator has been authorized to start working with the individual.

PTCM Responsibilities at Time of Discharge

1. Final Discharge Planning Meeting:

Schedule the "Final" discharge planning meeting to ensure all parties understand their responsibilities. The following should be invited and expected to attend:

- Participant/Guardian
- HCBS waiver or HOME Choice Case Manager (HCCM)
- Transition Coordinator
- Nursing Facility discharge planner
- Community-based case managers (Behavioral Health)
- Other providers as necessary
- Anyone the individual would like to attend

2. Roles & Responsibilities at discharge:

What is needed prior to the day of discharge? This may include the following items:

- Nursing home discharge planner orders any Durable Medical Equipment (DME)
- Determine medications and what will be provided on day of discharge
- Medicaid services have been ordered and services will begin on day of discharge or as necessary
- Transition coordinator has all housing items (bed, furniture, household items) purchased and will be in the house unpacked and ready for use.
- Determine who will be present at nursing home during discharge and who will be present at the individual's home
- If Medicaid services will not be in place at discharge, ensure HOME Choice services are authorized. HOME Choice services to be considered added at the time of discharge can include the following:
 - Community Support Coaching
 - Independent Living Skills Training Specialist
 - Nursing
 - Social work/Counseling
- Be available for assistance and support on moving day (At nursing home and residence)
- Ensure all supports and services are in place for health and safety

3. Transition to Community Case Manager:

Once the individual has transitioned and is settled in their home, the final responsibilities for the PTCM include the following:

- Within 1 business day, submit the enrollment form to HOME Choice Operations
- Transfer all pertinent information about the individual to the Waiver Case Manager/HOME Choice Case Manager

HOME Choice PTCM Forms & Tools

1. **Informed Consent Review:** Provides the individual with his/her rights and responsibilities as a participant in the HOME Choice program (We recommend this form be reviewed first in order for the individual to indicate if she/he wishes to participate in the program after knowing their role and responsibilities. This is also true for the guardian if there is one).

The image shows two pages of a form titled "HOME CHOICE - INFORMED CONSENT".

Page 1 of 2:

- Header: Ohio Department of Medicaid, HOME CHOICE - INFORMED CONSENT
- Participant Name (Last, First, MI) and Medicaid ID# (12 digits) fields.
- Section: RIGHTS AND RESPONSIBILITIES OF PARTICIPATION
- Text: "I understand and agree to the following requirements for participation in the Ohio HOME Choice program:"
- Text: "I will move from the nursing facility, ICF/IID, hospital or residential treatment facility to a qualified community residence. A qualified community residence is:
 - A residence owned or leased by me or my family; or
 - A residence in the community in which no more than 4 unrelated people reside.
- Text: "I will have resided in a nursing facility, ICF/IID, hospital and/or residential treatment facility at least 90 consecutive days before I move."
- Text: "I will have at least one Medicaid claim prior to my move."
- Text: "I will receive Pre-Transition Case Management services from HOME Choice that will include:
 - An assessment of my community living potential;
 - A review of services & resources available in the community through HOME Choice, waivers and/or Medicaid; and
 - Assistance with community transition planning.
- Text: "I will receive Transition Coordination services from HOME Choice that may include:
 - Help initiating the process to apply for benefits such as SSI and food stamps;
 - Help finding a place to live;
 - Help finding a doctor, pharmacy and other community resources; and
 - Help buying things I'll need to get set up in the community
 - o Up to \$2,000 of HOME Choice transition funds may be used for furniture, start-up groceries, personal items, application fees for apartments, security deposits, etc. Funds cannot be used for electronics, uniforms or memberships.
 - o Up to \$500 may be used for pre-transition transportation expenses.
- Text: "I must be Medicaid eligible to receive services from a Medicaid waiver or from Medicaid State Plan upon discharge from the facility to a qualified community residence and must be Medicaid eligible during the 365 days of participation in the HOME Choice program."
- Text: "My HOME Choice service plan and health outcomes will be monitored and reviewed by representatives from the HOME Choice program."
- Text: "I understand that my HOME Choice services will be available for up to 365 days of participation in the program. After my 365 days of participation in HOME Choice ends, I may continue to receive waiver or Medicaid state plan services as long as I meet the eligibility requirements."
- Text: "I understand and agree to the following responsibilities as a participant in the Ohio HOME Choice program:
 - I will actively participate in any assessments and/or meetings necessary to develop a service plan that assures my health and safety, and I will meet with my transition coordinator and pre-transition/post-transition case manager before and after my transition. Failure to do so may result in my termination from the HOME Choice process;
 - My participation in the HOME Choice program may be terminated if my health and safety cannot be assured in the community;
 - If I leave the facility against medical advice and/or prior to participating in plans to ensure a safe and orderly discharge to the community, I may forfeit the opportunity to participate in HOME Choice;
- Section: RIGHTS AND RESPONSIBILITIES OF PARTICIPATION (continued)

Page 2 of 2:

- Participant Name (Last, First, MI) and Medicaid ID# (12 digits) fields.
- Text: "I will provide full and accurate information (e.g. credit history, law enforcement involvement, rental history, personal history) to my HOME Choice providers so they may appropriately plan for and assist me with my transition to a community setting."
- Text: "My refusal to participate and follow my service plan may result in my termination from the HOME Choice program."
- Text: "I will meet and communicate with representatives from the HOME Choice program for up to two years after I discharge from the facility and I will be required to participate in a Quality of Life Survey before and after I have been enrolled in the program; and"
- Text: "I will promptly notify the HOME Choice program if I move during the follow-up period and will provide them with my new contact information."
- Text: "I understand that enrollment in the HOME Choice program is voluntary, therefore:
 - I agree to participate in the HOME Choice program and understand that information obtained by approved HOME Choice providers (Community Living Specialists, Pre-Transition Case Managers, etc.) may be shared with additional HOME Choice providers as part of my transition planning.
 - I do not want to participate in the HOME Choice program at this time. I understand that I may reapply for HOME Choice at a later date. This decision does not impact the services I am currently receiving.
- Signature lines for Applicant, Guardian, and Witness, each with a date field.
- Text: "Witness Relationship to Applicant" and "Address" fields.
- Text: "Pre-Transition Case Manager signature" and "Date" field.
- Section: GUARDIAN'S RESPONSIBILITIES
- Text: "As guardian of the person for someone participating in the HOME Choice Program, I agree to do the following:
 - Participate in discharge planning
 - Be available to participate in service planning meetings
 - Comply with all probate court required reporting requirements
- Signature line for Guardian and Date field.
- Contact information: HOME Choice Operations Unit, Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports, PO Box 162709, 5th Floor, Columbus, OH 43216-2709. E-mail: HOME_Choice@medicaid.ohio.gov, Fax: 614-466-6545, Phone: 888-221-1500.

Link: <http://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM02362fillx.pdf>

Key Areas of Importance on the Informed Consent:

- Understanding the individuals eligibility criteria for HOME Choice
 - o Qualified Institutional setting
 - o At least one Medicaid claim prior to discharge
 - o Transition to a Qualified Setting
 - Understanding the individuals role and responsibility as a participant
 - o Must be a willing participant in the HOME Choice program
 - o Leaving the facility prior to coordinating a safe discharge will cause termination from program
 - o Agree to follow-up surveys for up to two years after initial transition
 - Selection on the form whether the individual agrees or does not agree to participate in the program (Not agreeing means they will be denied participation in the program)
2. As you meet with the individual, review the person's chart, talk with staff, family, etc., to better understand whether you think the individual has "community living potential" and can be successful in the community. This will determine how you complete the Eligibility Checklist.

3. **Eligibility Checklist:** The information provided on the eligibility checklist helps ensure the individual is placed appropriately within the populations served in the program. In addition, it confirms eligibility requirements for the individual to participate. Please gather information from the participant as well as the staff at the facility. It is recommended the PTCM review the individual's chart to obtain all diagnoses and other information that could assist the individual's transition team.

Ohio Department of Medicaid
HOME CHOICE - ELIGIBILITY CHECKLIST

Applicant Name (Last, First, MI)		Anticipated Discharge Date (mm/dd/yyyy)	
Date of Birth (mm/dd/yyyy)		Medicaid ID # (12 digits)	
Facility Name		Facility Phone Number	
Facility Address (Street and #)			
City	Facility County	Zip Code	
Type of Facility (Check one.)			
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> ICF-ID	<input type="checkbox"/> Hospital	<input type="checkbox"/> Qualified Residential Treatment Facility (Children under age 22 only) <small>(To be a qualified institution, facility must be either a separate inpatient facility located in the community with 16 or more beds or part of a larger campus facility with 16 or more total beds.)</small>
LENGTH OF STAY			
NOTE: Participants must have a 90 day (consecutive) length of stay in long term care facilities (Hospital, NF, RTF, ICF-ID). The 90 days may include consecutive stays in multiple facilities.			
Has the participant met the 90 day (consecutive) length of stay requirement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No, is it anticipated that the 90 day minimum stay will be reached prior to discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has consumer had other stays? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, list facility name and dates of admission and discharge below.			
Stay 1	Facility Name	Date of Admission (mm/dd/yyyy)	Date of Discharge (mm/dd/yyyy)
Stay 2	Facility Name	Date of Admission (mm/dd/yyyy)	Date of Discharge (mm/dd/yyyy)
MEDICAID ELIGIBILITY - Please verify with facility.			
Has the participant had at least one Medicaid claim during their institutional stay? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not at this time			
RECOMMENDED HCB & PROGRAM			
DODD Waiver		ODM Waiver	
<input type="checkbox"/> Level 1 waiver		<input type="checkbox"/> Ohio Home Care waiver	
<input type="checkbox"/> IO waiver		<input type="checkbox"/> Transitions Carve-Out waiver	
<input type="checkbox"/> SELF waiver			
ODA Waiver		Non-Waiver Medicaid	
<input type="checkbox"/> PASSPORT waiver		<input type="checkbox"/> Medicaid card/state plan services	
<input type="checkbox"/> Assisted Living waiver			

ODM 02369 (Rev. 7/2013) Page 1 of 2

Applicant Name (Last, First, MI)

QUALIFIED RESIDENCE

Has the participant found housing? Yes No

If Yes, is the housing a qualified residence? Yes No

If No, is it anticipated that the participant will move into a qualified residence at the time of discharge? Yes No

Qualified Resident Type (Information on qualified housing can be found in OAC 5101:3-51-01.)

Qualified Residences for HOME Choice must have all the following in order to meet eligibility criteria:

- An individual lease or agreement that satisfies all applicable statutes regarding Tenant and Landlord law.
- Lockable access and egress to the individual's unit.
- Sleeping, bathing, and cooking areas within the unit over which the individual or the individual's family has domain and control; &
- House no more than four unrelated individuals reside within the unit itself. Individuals may live in a complex with multiple units (i.e. a duplex apartment building), but within an individual unit/home, there may be no more than four unrelated individuals.

Note: Many licensed facilities do not provide residents with individual leases, or provide agreements that do not meet applicable Tenant/Landlord law. When a lease is in doubt, please contact the HOME Choice Operations Unit for review.

EMPLOYMENT

Interested in employment Not interested in employment

Currently employed Other

DIAGNOSES/ COMMENTS: Please provide details that identify strengths, needs, barriers & relevant diagnoses.

Does this person have community living potential? Do you think he/she can be successful and sustainable in the community at this time?
 Yes No, explain:

COMPLETED BY:

Name (Please print.) _____ Phone _____ Date (mm/dd/yyyy) _____
Ext. _____

AGENCY ODA DODD ODM Case Management
PSA Region _____ County _____ Agency Name _____

Send completed form to:
HOME Choice Operations Unit
Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports
PO Box 162709, 5th Floor
Columbus, OH 43216-2709
Email: HOME_Choice@medicaid.ohio.gov
Fax Number: 614-465-6945 Phone: 688-221-1560

ODM 02369 (Rev. 7/2013) Page 2 of 2

Key Areas of Importance on the Eligibility Checklist:

- Facility Address and phone number
- Length of Stay
 - Include hospital and nursing home if there is no break in stay
 - Additional facility information to help ensure eligibility
- Home and Community Based Information
 - Be sure to designate the correct recommended waiver
- Diagnoses and Comments (provide as much as possible)

4. **Community Readiness Tool (CRT):** The CRT is the program’s “**Assessment Tool**” that is reviewed by the CLA and distributed to the transition coordinator to help provide detailed information about the individual. As you complete the CRT, be sure to provide not only what has been discussed but any additional observations that would be beneficial to the transition coordinator. This tool, including the informed consent and eligibility checklist, will be used to provide base-line of information for the transition coordinator to assist the individual as they return to the community.

Ohio Department of Medicaid HOME CHOICE Community Readiness Tool		
HOME CHOICE APPLICANT		
Last Name	First Name	MI
Medicaid ID #	Date of Birth	
Who is present at the meeting?		
PRE-TRANSITION CASE MANAGER (PTCM)		
Name		Date Completed
Agency	Email	Phone Number
ELIGIBILITY		
1. Where is the individual currently residing?		
<input type="checkbox"/> Hospital <input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disabilities <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Residential Treatment Center with 16 or more beds (and the individual is under the age of 22) <input type="checkbox"/> None of the above (STOP – THE INDIVIDUAL IS INELIGIBLE; DOCUMENT ON ELIGIBILITY CHECKLIST WITH COMMENTS)		
Comments or Observations:		
2. Does the individual have a legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes, please indicate the type of guardian.</i>		
<input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Person and Estate		
Guardian Name	Guardian Phone Number	
Guardian Address		
3. Is the individual legally permitted to leave the institution and relocate to a community setting?		
<input type="checkbox"/> Yes <input type="checkbox"/> No (STOP – THE INDIVIDUAL IS INELIGIBLE; DOCUMENT ON ELIGIBILITY CHECKLIST WITH COMMENTS)		
<i>If no, please describe the situation (e.g. court ordered placement) here and also send an email to the HOME Choice Operations Unit alerting them of the situation.</i>		
4. Are there any communication barriers? (e.g. language, vision, hearing, literacy)		
<i>If the individual is under the age of 18, answer this question for the individual's family.</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Comments or Observations		
ODM 10180 (5/2016)		
Page 1 of 9		

Link: <http://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM10180fillx.pdf>

Key Areas of Importance on the CRT:

- Review CRT and strive to make it a “conversational” assessment that opens the individual to be more talkative which will provide more information
- Every section is important and must be filled out
- Document your observations (Not just what’s in the chart)
- Verifying Income and if the individual has no income, refer them to an SSI Specialist

5. **HOME Choice Service Plan:** The service plan authorizes all services for the individual. It is not authorized by the PTCM but is submitted to HOME Choice Operations as recommendations. The official authorization is determined and processed by the CLA. Submit the service plan with the selected transition coordinator agency (selected by the individual/guardian) and community transition services added to the plan. When applicable, Community Support Coaching is the only service that can be added prior to transition, but all other services should not be added until the individual is in the community and it is determined at the final discharge planning meeting that other services would be a benefit to the individual.

Example of a HOME Choice Authorized Service Plan

Date(s) Begin and/or End date		HOME Choice Service Code	Span Unit(s)	Cost	HC Provider Number/ Provider Name, Phone
8/3/2016 -	HC018 - Pre-Transition Case Management	1	\$0.00	HC1613 - CareSource, 216-896-8173	
8/19/2016 -	HC009 - Community Transition Services	2	\$0.00	HC1636 - Easter Seals Central and Southeast Ohio, 614-228-5523	
8/19/2016 -	HC009 - Community Transition Services	1	\$0.00	HC1636 - Easter Seals Central and Southeast Ohio, 614-228-5523	
8/19/2016 -	HC010 - Transition Coordination	1	\$0.00	HC1636 - Easter Seals Central and Southeast Ohio, 614-228-5523	

Key Areas of Importance on the Service Plan:

- Individuals information is required
- Provider Name and Provider Number must be given
- Begin date should be left blank when submitting to HOME Choice for approval

6. **Transition Coordinator List:** This information is found on the home page of the HOME Choice website. When you do your face to face visit, make sure you have the most up-to-date printed list. If you have the option to review the website with the individual, that is also acceptable. We recommend you check the website once a month to ensure you have the most recent list. When providing the list to the individual, you may provide additional information about each transition coordinator agency that can help the individual make an informed decision.

The Transition Coordinator list can be found here:

<http://www.medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx>

The screenshot shows the HOME Choice website interface. At the top is a navigation bar with tabs: HOME, MEDICAID 101, FOR OHIOANS, PROVIDERS, INITIATIVES, NEWS, RESOURCES, CAREERS, and CONTACT. Below the navigation bar is a breadcrumb trail: FOR OHIOANS > Programs > Home Choice. The main heading is "HOME Choice: Helping Ohioans Move, Expanding Choice". Below this is a video player titled "HOME Choice: 2015 Consumer Success Stories" featuring three individuals: Teri, Ernest, and Doris. The Ohio Department of Medicaid logo is visible in the bottom left of the video player. To the right of the video player is a "Related Content" section with a list of links: Vision and Mission, Information Card, Fact Sheet, HOME Choice Contact List, HOME Choice Bulletin, Consumer Advisory Council, and Olmstead Taskforce. Below that is a "Find a HOME Choice Provider" section with a list of options: By Provider Type, By County, and Transition Coordinator List. A red arrow points to the "Transition Coordinator List" option.

Key Areas of Importance when discussing TC list with the individual:

- Ensure the list is up to date
- Provide general information about each Transition Coordinator Agency
- Respond to any questions when prompted by the individual

7. **Provide Community-based services (ODM Form 02399):** If applicable, provide community-based services and signature to be submitted to the local county department of job and family services.

The pdf version of the 02399 form can be found here:

<http://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM02399fillx.pdf>

8. **Contact Information:** Once the assessment is complete and the individual has signed all required documentation, provide the individual with contact information that shall include the following:

Important HOME Choice Contact Information

Please give this information to the Individual

My Numbers
Cell phone
Phone number at facility
Phone number at new home

Pre-Transition Case Manager
Name
Office phone
Cell phone

HOME Choice Transition Coordinator
Name
Office phone
Cell phone

Other contacts	
Name	Number
HOME Choice Main Number	1-888-221-1560

Please provide the HOME Choice main office number in the 'Other Contacts listed above

RESOURCES

A. HOME Choice Operations Contact Information.....	21
B. HOME Choice Roles and Responsibilities (PTCM, TC, HCCM).....	24
C. Forms & Tools.....	26
D. Change In Status Form.....	28
E. HOME Choice Website Information.....	29
F. Training Updates and Resources.....	30
G. HOME Choice Pre-Transition Case Management Provider Agreement.....	31

A. HOME Choice Operations Contact Information

Website: <http://medicaid.ohio.gov/HomeChoice>

Please submit all HOME Choice documents and forms via **EMAIL** to HOME_CHOICE@medicaid.ohio.gov or by **FAX** to (614) 466-6945

IF YOU NEED:	CONTACT:
<p>Basic Information on the HOME Choice program, questions on status of applications, updates to provider contact information, assistance with provider applications, website information, etc.</p>	<p>Angela Walls Call: 1-888-221-1560 Email: Angela.Walls@medicaid.ohio.gov</p>
<p>Intake Coordinators process the HOME Choice applications and referrals, provide technical assistance and support.</p>	<p>Daniel Hageman Bonnie Hubbard- Nicosia Call: 1-888-221-1560 Email: HOME_Choice@medicaid.ohio.gov</p>
<p>HOME Choice Caseload for children age 21 and under (e.g. case specific inquiries, service planning, technical assistance for population type, or Medicaid services both waiver or non-waiver)</p>	<p>Jessica Hawk Call: (614) 752-3516 Email: Jessica.Hawk@medicaid.ohio.gov</p>
<p>HOME Choice Caseload for persons age 22 through 59 with physical disabilities (e.g. case specific inquiries, service planning, technical assistance for population type, or Medicaid services both waiver or non-waiver)</p>	<p>Laurie Damon Call: (614) 752-3576 Email: Laurie.Damon@medicaid.ohio.gov</p>
<p>HOME Choice Caseload for persons age 22 and older with primary mental health needs and/or substance use disorders (e.g. case specific inquiries, service planning, technical assistance for population type, or Medicaid services both waiver or non-waiver)</p>	<p>Karen Jackson Call: (614) 752-3789 Email: Karen.Jackson@medicaid.ohio.gov Joni Janowiak Call: (614) 752-3016 Email: Joni.Janowiak@medicaid.ohio.gov</p>
<p>HOME Choice Caseload for persons age 60 and over and for persons age 22 and older with developmental disabilities (e.g. case specific inquiries, service planning, technical assistance for population type, or Medicaid services both waiver or non-waiver)</p>	<p>Yvette Weaver Call: (614) 752-3555 Email: Yvette.Weaver@medicaid.ohio.gov</p>
<p>Provider Administration Provider Training, Technical Assistance, Criteria, Provider Communications, Website, Forms, Billing/Payment questions, etc.</p>	<p>Brock Robertson Call: (614) 752-3577 Email: Brock.Robertson@medicaid.ohio.gov</p>
<p>Provider Oversight & Compliance Protection from Harm/Incident Reporting, Technical Assistance, Compliance Reviews, etc.</p>	<p>Angie Reed Call: (614) 387-8121 Email: Angela.Reed@medicaid.ohio.gov</p>
<p>Minimum Data Set - Section Q Referrals, technical assistance, criteria, invoicing, training, CLPA web application, MDS reports, Quality of Life Survey contract & reports, etc.</p>	<p>Becky Kuhn Call: (614) 752-3554 Email: Rebecca.Kuhn@medicaid.ohio.gov</p>
<p>Education and Outreach Develops program information and outreach materials, reviews HOME Choice brand requests, liaison to HOME Choice Consumer Advisory Council and Ohio Olmstead Task Force stakeholder groups</p>	<p>Edward Gibson Call: (614) 752-4014 Email: James.Gibson@medicaid.ohio.gov</p>
<p>HOME Choice MFP Initiatives Manager Oversight and development of MFP initiatives, manages collaborative partnerships with MyCare and Medicaid Managed Care</p>	<p>Carol Schenck Call: (614) 387-7755 Email: Carol.Schenck@medicaid.ohio.gov</p>

<p>MFP Project Director and HOME Choice Operations Program oversight and administration, policy review, customer service issues, manage operations workflow and HOME Choice staff, general inquiries, budget and policy, etc.</p>	<p>Jane Black Call: (614) 752-3567 Email: Jane.Black@medicaid.ohio.gov</p>
<p>Provider Claims, Billing issues, Process, Questions regarding payment, Website Portal, etc.</p>	<p>Morning Sun Financial Management Services http://www.morningsunfs.com/</p>
<p>Housing Assistance HOME Choice or general Medicaid housing inquiries regarding subsidy programs, fair housing, accommodations, etc. Oversight and support of SSI Ohio, Ohio Temporary Ramp program, Home for Good, 811 Housing Subsidy and the ODM Subsidy</p>	<p>Emily VanBuren Call: (614) 752-3805 Email: Emily.VanBuren@medicaid.ohio.gov Jeannette Welsh Call: (614) 752-3406 Email: Jeannette.Welsh@medicaid.ohio.gov</p>
<p>HOME Choice Data Reporting, Analysis, Database Management Federal reporting, data projects, data integration and analysis, etc.</p>	<p>Eric Mundy Call: (614) 752-3826 Email: Eric.Mundy@medicaid.ohio.gov</p>
<p>MFP liaison for the Department of Mental Health and Addiction Services (MHAS) & Recovery Requires a Community Training, Resources, HOME Choice provider assistance with Recovery Requires a Community, Community Transitions & RSS resource</p>	<p>Ellie Jazi Call: (614) 466-6783 Email: Recovery@mha.ohio.gov Email: Ellie.Jazi@mha.ohio.gov</p>
<p>MFP liaison for the Department of Developmental Disabilities Training for county boards/providers, Technical Assistance, DC, IID/ICF community transitions.</p>	<p>Sara Lawson Email: Sara.Lawson@dodd.ohio.gov HOME Choice website link to DD training: http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice/TrainingUpdates.aspx</p>
<p>SUCCESS Project Transitional funds for Persons not eligible for HOME Choice who are moving out of a nursing facility and receiving Medicaid. Other eligibility criteria apply. Case by case review.</p>	<p>Laurie Damon Call: (614) 752-3576 Email: Laurie.Damon@medicaid.ohio.gov</p>

RELEVANT WEBSITES

[Ohio Home Care Waiver](#)
[MyCare Ohio](#)
[Department of Medicaid](#)
[Department of Aging](#)

[Department of Developmental Disabilities](#)
[Department of Mental Health and Addiction Services](#)
[Office of Health Transformation](#)

C. Roles & Responsibilities (PTCM, TC, HCCM)

"Condensed" Version (9/25/2014) – Based on Provider Agreements/Contracts (HOME Choice & Waivers)

Please see non-condensed version of the Roles and Responsibilities for the full listing of duties and expectations for HOME Choice TC's, PTCM's and case managers based upon the Provider Agreements for each of these positions.

	Pre-Transition Case Manager (PTCM)	Transition Coordinator (TC)	HCBS Program Waiver Assessor and HC Case Managers (waiver or non-waiver)
Pre-Transition	<ul style="list-style-type: none"> • Make initial contact with applicant within 3-5 business days • Conduct face-to-face with applicant within 10 business days • Complete the <i>Community Readiness Tool</i>, the <i>Informed Consent Form</i>, and the <i>Eligibility Checklist</i> • Recommendation for HOME Choice (HC) • If recommending HC: select either waiver or non-waiver support (if waiver is selected, complete ODM 2399) • Review Transition Coordinator (TC) list with applicant • Enter applicant's preferred TC on the HC Service Plan • Educate applicant on the HC process • If NOT recommending HC: Share community resources and indicate enrollment not recommended with explanation on <i>Eligibility Checklist</i> • Within 3 business days of face-to-face, submit to HC Operations: <i>Eligibility Checklist, Informed Consent, Community Readiness Tool</i>, and <i>HC Service Plan</i> • Obtain regular updates from the TC needed 	<ul style="list-style-type: none"> • Replies to referral from HC within 3 business days • Contact applicant within 3 to 5 business days to acceptance • Review documentation received • Conduct face-to-face with individual within 7-10 business days of initial contact • Assist with formulating a transition plan • Communicate updates regularly with the PTCM • Assist with Housing Transition Activities (Relocation Workbook to determine needs) <ul style="list-style-type: none"> – Finding safe and affordable housing – Overcoming potential barriers – Housing or modification subsidy – Complete housing applications and arrange for payment of application and housing fees – Visit residence – Complete the <i>Qualified Residence Statement</i> – Obtain copy of lease/residence verification form • Submit <i>Qualified Residence Statement</i> • Benefits and Financial Activities <ul style="list-style-type: none"> – Assess financial sustainability – Establish a budget – Assist with benefit coordination – Assist with employment (if applicable) • Assist with purchase of goods and services for transition 	<ul style="list-style-type: none"> • Report to PTCM, TC and HOME Choice operations regarding outcomes of Waiver Assessment

<p>Pre-Transition Discharge Planning</p>	<ul style="list-style-type: none"> • Schedule, facilitate and participate in discharge planning meetings • Determine post discharge HC services, contact HC providers, update HC service plan and submit to HC operations Unit • Ensure HC Services are in place if waiver or state plan services can't start at discharge • Schedule and facilitate final discharge planning meeting • Have team sign off on assignment and coordinate final prep for moving day 	<ul style="list-style-type: none"> • Participate in discharge planning meetings • Determine post discharge HC services and community services • Coordinate transition with behavioral health and substance abuse providers • Provide Linkages to community resources and employment options • Ensure HC services are in place if waiver or state plan services can't start at discharge • Attend final discharge planning meeting • Sign off on assignments and coordinate final prep for moving 	<ul style="list-style-type: none"> • Meet with individual within 5 business days of receipt of <i>HC Service Plan</i> (HCCM) • Determine post discharge HC services, waiver services, or state plan services • Identify provider roles and responsibilities for the day of discharge • Ensure HC services are in place if waiver or state plan services can't start at discharge • Attend final discharge planning meeting • Sign off on assignments and coordinate final prep for moving
<p>Day-of-Transition</p>	<ul style="list-style-type: none"> • Transfer all pertinent information about participant to Waiver Case Manager or HOME Choice Case Manager • Be available for assistance and support on moving day • Complete and submit the <i>HC Enrollment Form</i> within 1 business day of discharge • Coordinate that all services and supports are in place; that the individual has what they need to be safe and healthy 	<ul style="list-style-type: none"> • Provide updates and relevant information to Case Managers • Assist the participant with moving • Share information with other HC providers and community service providers (residence is "move-in ready"; food; medications; furniture; etc.) 	<ul style="list-style-type: none"> • Provide 24 hours contact information and document a back-up plan for participant • Be available for assistance and support on moving day • Receive and review information from PTCM and TC regarding the individual's needs for services and supports (HC documents)
<p>Post Transition Activities</p>	<p>N/A</p>	<ul style="list-style-type: none"> • Submit the <i>TC Summary Form</i> and <i>Lease Verification Form</i> (if not previously submitted) to HC operations within 10 days post discharge • Contact participant at least 5 times, including 2 face-to-face visits during the first 90 calendar days post discharge • Submit <i>Post-Transition Activities Form</i> between the 90-100th day in community • Report any incidents to the Case Manager • Submit <i>HC Change in Status form</i> as necessary 	<ul style="list-style-type: none"> • Maintain contact with all service providers and assess the need for additional services • Schedule and facilitate at least 1 post-discharge meeting with the TC, the individual and other providers within the first 80 days of discharge • Contact the individual at least once per month • Be responsible for incident reporting • Submit <i>HC Change in Status Form</i> as necessary • Assist with housing re-certification; request emergency housing and rental assistance through the TC as necessary • Organize and facilitate a meeting at least 30 days prior to the HC participants 365th day in the program

A. Forms and Tools

The timely submission of all forms is expected and very important. The HOME Choice website contains the most current forms, tools and resources. Providers will receive an email communication when there are any updates

Forms and tools are found on the HOME Choice website at the following address:

<http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice/HCTools.aspx>

► TRANSITION COORDINATION & CASE MANAGEMENT FORMS

- [ODM 02360 - Home Choice Summary of Transition Coordination Activities](#)
- [ODM 02365 - Home Choice Demonstration and Supplemental Services Plan](#)
- [ODM 02367 - Home Choice Transition Coordination Qualified Residence Statement](#)
- [ODM 02368 - Home Choice Enrollment Request](#)
- [ODM 02369 - Home Choice Eligibility Checklist](#)
- [ODM 02371 - Home Choice Change in Status](#)
- [ODM 02362 - Home Choice Informed Consent](#)
- [ODM 02361 - Home Choice Application](#)
- [ODM 10181 - Home Choice Residence Verification Document \(Security Deposit or First Month Rent Request\)](#)
- [ODM 10182 – Home Choice Payment Request](#)
- [ODM 10183 – Home Choice Service Claim Request](#)

► HOME CHOICE TOOLS

- [Case Manager Checklist](#)
- [Community Readiness Tool](#)
- [Emergency Rental and Utility Assistance Request](#)
- [Estimated Use of Transition Funds Worksheet](#)
- [Goods and Services Guidelines](#)
- [Goods and Services Usage Log](#)
- [HOME Choice Case Management Contact List](#)
- [HOME Choice Who's Who](#)
- [Housing Navigation Request](#)
- [Morning Sun Financial Services Website](#)
- [Move-In Ready Checklist](#)
- [Recovery Requires a Community Website](#)
- [Service Provider Manual](#)
- [Summary of Post-Transition Activities](#)
- [TC Provider Manual](#)
- [TC Planning Document / To-Do Checklist](#)
- [TC Relocation Workbook](#)
- [Transportation Funds Guidelines](#)

D. Change in Status Form

Participant Name <i>(Last, First, MI)</i>		Medicaid ID # <i>(12 digits)</i>		
Section 1: PRE-ENROLLMENT TERMINATION				
<i>Complete Section 1 <u>only</u> if participant terminates or withdraws <u>before enrollment</u> into the program.</i>				
Effective Date <i>(mm/dd/yyyy)</i>				
Reason <i>(Check one below.)</i>				
<input type="checkbox"/> Too physically ill	<input type="checkbox"/> Individual would not cooperate in care plan development			
<input type="checkbox"/> Too cognitively impaired	<input type="checkbox"/> Service needs greater than what could be provided in the community			
<input type="checkbox"/> Mental health needs exceed capacity of program to meet them	<input type="checkbox"/> Death			
<input type="checkbox"/> Guardian refused participation	<input type="checkbox"/> Individual did not choose MFP qualified residence			
<input type="checkbox"/> Could not locate appropriate housing arrangements	<input type="checkbox"/> Could not secure affordable housing			
<input type="checkbox"/> Individual changed his/her mind	<input type="checkbox"/> Other <i>(You must specify.)</i>			
Section 2: INSTITUTIONALIZATION OR TRANSFER FROM ONE FACILITY TO ANOTHER AFTER ENROLLMENT				
<i>Complete Section 2 <u>only</u> if participant is admitted to a facility <u>after enrollment</u> into the program.</i>				
Admission from				
<input type="checkbox"/> Residence <input type="checkbox"/> Another Institution				
Admission Date <i>(mm/dd/yyyy)</i>				
Facility Name				
Facility Address		City	State	Zip
Facility Type <input type="checkbox"/> Nursing Facility <input type="checkbox"/> ICF/IID <input type="checkbox"/> Hospital <input type="checkbox"/> Residential Treatment Facility				
<input type="checkbox"/> Other <i>(Specify.)</i>				
Reason for Institutionalization <i>(Check one.)</i>				
<input type="checkbox"/> Acute care hospitalization followed by long term rehabilitation		<input type="checkbox"/> Loss of housing		
<input type="checkbox"/> Deterioration in cognitive functioning		<input type="checkbox"/> Loss of personal caregiver		
<input type="checkbox"/> Deterioration in health		<input type="checkbox"/> By request of participant/guardian		
<input type="checkbox"/> Deterioration in mental health		<input type="checkbox"/> Lack of sufficient community services		
Section 3a: RESIDENCE INFORMATION				
<i>Complete Sections 3a and 3b if participant is discharged from a facility back into the community OR moves from one qualified residence to another after enrollment into the program. All fields are required information.</i>				
Move Type		Effective Date <i>(mm/dd/yyyy)</i>		
<input type="checkbox"/> Discharge from Facility <input type="checkbox"/> Change in Residence				
Current Phone # <i>(xxx-xxx-xxxx)</i>	Residence Address			
City	County	State	Zip	
Is participant living with family? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Participant Name <i>(Last, First, MI)</i>	Medicaid ID # <i>(12 digits)</i>
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Section 3b: RESIDENCE TYPE
 Complete **both parts of section 3b** when participant moves from one qualified residence to another or is discharged from a facility.

IS THE RESIDENCE

A residence in a community-based residential setting in which no more than 4 unrelated individuals reside? If so, indicate residence type. *(Check one.)*

<input type="checkbox"/> Adult foster homes	<input type="checkbox"/> Adult family homes
<input type="checkbox"/> Non-ICF/IID residential facilities	<input type="checkbox"/> Family foster home for children
<input type="checkbox"/> Type 1 residential facilities	<input type="checkbox"/> Type 2 residential facilities
<input type="checkbox"/> Treatment foster home for children	<input type="checkbox"/> Group homes for children
<input type="checkbox"/> Medically fragile foster home	<input type="checkbox"/> Pre-adoptive infant foster home for children

OR, is the residence

A home owned/rented by the participant

A home owned/rented by a family member or friend

An apartment/house leased by the participant (not assisted living)

An apartment leased by the participant (assisted living)

HOUSING SUPPLEMENT(S) OBTAINED FOR HOME OR RESIDENCE *(Check all that apply.)*

<input type="checkbox"/> Low income housing tax credit unit	<input type="checkbox"/> Unit subsidized with HOME funds
<input type="checkbox"/> Section 202 unit	<input type="checkbox"/> Unit subsidized with Housing Trust Funds
<input type="checkbox"/> Unit subsidized with CDBG funds	<input type="checkbox"/> VA subsidy
<input type="checkbox"/> USDA Rural Development unit	<input type="checkbox"/> Funds for assistive technology for housing
<input type="checkbox"/> Funds for home modification	<input type="checkbox"/> Section 811 unit
<input type="checkbox"/> Housing Choice Vouchers	<input type="checkbox"/> Other <i>(Describe.)</i>
	<input type="checkbox"/> Not Applicable

Section 4: DISENROLLMENT FROM HOME CHOICE
 Complete *only if participant terminates the program after enrollment.*

Effective Date *(mm/dd/yyyy)*

Reason *(check one)*

<input type="checkbox"/> Moved to an institutional setting (Complete Section 2.)	<input type="checkbox"/> Completed 365 days of participation in program
<input type="checkbox"/> Death of participant	<input type="checkbox"/> Suspended eligibility
<input type="checkbox"/> Moved (Complete section 3a.)	<input type="checkbox"/> No longer needed services
<input type="checkbox"/> Other <i>(You must specify.)</i>	<input type="checkbox"/> Loss of Medicaid

Section 5: COMPLETED BY

Name	Agency	Phone	Ext
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Send completed form to:
 HOME Choice Operations Unit
 Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports
 PO Box 182709, 5th Floor
 Columbus, OH 43218-2709

Email: HOME_Choice@medicaid.ohio.gov
 Fax Number: 614-466-6945

E. Website Information

<http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx>

► What has been updated?

- A new **“Transition Team”** page that describes the roles of the individuals who work closely with HOME Choice participants (PTCM, TC and Case Manager)
- An **updated page specifically for Service Providers** with links to the Provider Agreement, finding a provider, and other provider related content (forms, tools, training updates)
- A new **“Training Updates”** page that provides agendas, presentations and handouts from different HOME Choice training days, in addition to some other resources that providers might find useful
- A **remodeled and updated Housing page** that accurately reflects the available resources for individuals searching for qualified and affordable housing options

HOME PAGE

- Updated statistics, new fact sheets and information cards, and a redesigned format highlight the home page
- The **“Learn More”** button will take you to the Consumer Page
- The **HOME Choice Provider Links** include the following pages:
 - Resources (formerly the “Provider Page”)
 - Housing
 - Community Living Specialist

INDIVIDUALS INFORMATION

- The Ohioans Page provides information for people interested in the program
- The **“Apply for HOME Choice”** button opens a PDF version of the application.
- The **Transition Team link** opens a new page that describes the role of the providers who will work with the individual through transition
 - Pre-Transition Case Manager
 - Transition Coordinator
 - HOME Choice Case Manager

SERVICE PROVIDERS

- Service Provider information is now consolidated into one page for information, application and links to forms, tools and trainings
- **Instructions** for how to complete the Service Provider application are now easily accessible on the information page
- A large button highlights the **Service Provider Agreement**
- The **Related Contents** sidebar includes links to a new **Training Updates** page with additional resources and the **Provider Forms and Tools** page for necessary ODM forms and tools

TRAINING UPDATES

- Training Updates and additional helpful resources and tools are now all together on one page for easy access
-
- Recent and historical training materials can be found here including agendas, presentations and handouts
- The **Additional Resources** section is where helpful tools and documents can be found to assist the provider during the individual’s transition

HOUSING

- The Housing Page includes helpful links, resources and contact information for individuals in need of affordable housing
- **Housing Links** are included to connect individuals with potentially affordable, accessible and available housing throughout the state
- Up-to-date **contact information** for ODM’s Housing Coordinators
- The **Related Contents** sidebar includes links to current housing initiatives, helpful resources and informational documents

COMMUNITY LIVING SPECIALISTS

- Recent updates to the HOME Choice webpages didn’t affect the Community Living Specialists page
- Additional information was added for context and helpful resources were included for informational purposes
- The **Community Living Plan Addendum** web application and **Instructions** can now be found on this page
- Other information on this page includes FAQ documents and information about Section Q of the MDS 3.0 RAI

F. Training Updates and Resources

<http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice/TrainingUpdates.aspx>

▶ PTCM, TC and HCCM Training – Fall 2015:

- [Agenda](#)
- [Social Security Administration Presentation](#)
- [Social Security Administration Q&A](#)
- [Protection from Harm & MyCare/MMP Presentation](#)
- [New: Audio Version of the Protection from Harm Presentation](#)
- [New: Script Version of the Protection from Harm Presentation](#)
- [HOME Choice Updates Presentation](#)
- [HOME Choice Housing Presentation](#)
- [HOME Choice Infant, Children, and Youth Presentation](#)
- [HOME Choice "Jeopardy" Presentation](#)

▶ Developmental Disabilities Training – Summer 2015:

- [Agenda and Handouts](#)
- [Overview Presentation](#)
- [Process Presentation](#)

▶ Service Provider Training – Spring 2015:

- [Agenda and Handouts](#)
- [Overview Presentation](#)
- [Protection From Harm Presentation](#)
- [Roles and Responsibilities](#)

▶ HOME Choice Criminal Background Webinar – March 2015:

- [HOME Choice Criminal Background Presentation](#)
- [Housing Barriers for Sex Offenders Presentation](#)
- [Expungement Record Sealing Power Point Presentation](#)
- [Juvenile & Adult Side-by-side Information](#)

▶ PTCM, TC and HCCM Workshops – Summer 2014:

- [Agenda](#)
- [Summer Presentation](#)
- [SSI Ohio Presentation](#)
- [Fair Housing Presentation](#)

▶ HOME Choice Redesign – Summer 2013:

- [Redesign Presentation](#)
- [Housing and Qualified Residence Statement Presentation](#)

▶ Additional Resources

- [Community Support Coach vs. Independent Living Skills Training Specialist](#)
- [Condensed Roles and Responsibilities for TC's, PTCM's and Case Managers](#)
- [Data Base Service Plan Sample with Itemized Instructions and Reference Points](#)
- [Goods and Services Guidelines](#)
- [HOME Choice Related Waivers Comparison Chart](#)
- [HOME Choice Transition Team Participation from Pre-Transition through Completion of 365 Days](#)
- [Local Community Based Waiver Contact Information](#)
- [MyCare Ohio Contact Information](#)
- [MyCare Ohio Map](#)
- [Recovery Requires a Community](#)
- [Regional Ombudsman Contact Information](#)
- [SSI Ohio Project Contact List](#)
- [Transportation Funds Guidelines](#)

G. Pre-Transition Case Management Provider Agreement

This provider agreement (“Agreement”) is a contract between the Ohio Department of Medicaid (ODM) and the undersigned Pre-Transition Case Management (“PTCM”) Agency to provide pre-transition case management services under the HOME Choice Demonstration Program. Under this Agreement, the HOME Choice PTCM Agency will be responsible for assessing whether HOME Choice applicants are eligible to participate in the HOME Choice program, and for providing pre-transition services and oversight to ensure the participants’ successful transition to the community.

HOME Choice pre-transition case management services are available to all HOME Choice applicants. The PTCM agency may or may not be the same agency providing HOME Choice case management post-discharge once a participant has been successfully transitioned to the community.

A. Upon receiving a referral from ODM’s HOME Choice Operations Unit, the PTCM Agency shall:

1. Contact the institution and/or the HOME Choice applicant to schedule a face-to-face visit with the applicant. This contact shall take place within 3 – 5 business days of receipt of the HOME Choice referral.
2. Determine if the applicant has a guardian. If the applicant has a guardian, the PTCM Agency shall contact the guardian prior to scheduling the face-to face-meeting.
3. Schedule and facilitate the face-to-face meeting with the applicant/guardian within 10 business days of receipt of the HOME Choice referral.

B. During the face-to-face meeting, the PTCM Agency shall:

1. Complete the HOME Choice Community Readiness Tool.
2. Provide waiver information to the applicant/guardian and have the applicant/guardian sign the ODM02399 “Request for Medicaid Home and Community Based Services (HCBS)” form if applicable. The signed form shall be submitted by the PTCM to the local county department of job and family services for processing.
3. Review the HOME Choice ODM02362 “HOME Choice-Informed Consent” form with the applicant/guardian and obtain the applicant/guardian’s signature.
4. Review the Qualified Residence fact sheet as it relates to HOME Choice eligibility criteria.
5. Complete the JODM 02369 “HOME Choice Eligibility Checklist” form. Based on the community readiness tool, dialogue, observations and other information shared during the face-to-face meeting, the PTCM Agency shall:
 - a. Provide comments on this form that reflect its professional opinion of whether the applicant should proceed with the HOME Choice process/program, not as a determination but as an observation.
 - b. Identify whether it recommends approval for participation in the HOME Choice program by selecting the appropriate check box. (Please note that ODM’s HOME Choice Operations Unit will make the final determination).
 - c. Provide comments on the ODM 02369 “HOME Choice-Eligibility Checklist” form that reflect the PTCM Agency’s assessment of whether the applicant may be eligible to participate in a waiver program, not as a determination but as an observation. (For example: “No, because the applicant’s health and safety cannot be assured by the program”, or “The applicant’s needs can be met by community resources”.)
6. Review the list of Transition Coordination Agencies with the applicant/guardian, taking into account the applicant’s disabilities and needs, and enter the applicant’s first choice of a Transition Coordination Agency onto the ODM 02365 “HOME Choice Demonstration and Supplemental Services Plan”. The PTCM will also add Community Transition Services onto the service plan.
7. Provide information regarding HOME Choice Services to the applicant, guardian, family, institution, and other appropriate individuals.
8. Review with the applicant how Community Transition Services may be used, and the role of the Transition Coordinator regarding Community Transition Services funds in accordance with rule.
9. Share additional community resources and living options with the applicant/guardian as may be appropriate when HOME Choice is not going to be recommended.

C. Following the face-to-face meeting with the applicant, the PTCM Agency shall complete and submit the required documentation as follows:

1. When recommending approval of the applicant to the HOME Choice Program, the PTCM Agency will submit the ODM 02369 "HOME Choice-Eligibility Checklist", ODM 02362 HOME Choice-Informed Consent" form, Community Readiness Tool and ODM 02365 "HOME Choice Demonstration & Supplemental Services Plan" form to the HOME Choice Operations Unit. The PTCM Agency shall provide copies of these documents to the applicant/guardian, and maintain a copy of these documents in the applicant's file.
2. When not recommending approval of the applicant to the HOME Choice Program, the PTCM Agency will submit the ODM 02362 "HOME Choice-Informed Consent" and/or ODM 02369 HOME Choice- Eligibility Checklist" form to the HOME Choice Operations Unit.

D. Once an applicant has been approved by the HOME Choice Operations Unit, they become a participant in the HOME Choice Program. During the participant's pre-transition period, the PTCM Agency shall:

1. Obtain regular status updates from the Transition Coordination Agency.
2. Schedule and participate in discharge planning meetings with the participant/guardian, Transition Coordinator, discharge planners and others as requested by the participant.
3. Assist with linkages to service providers and community resources.
4. Fill out and submit to the HOME Choice Operations Unit an ODM 02371 "HOME Choice-Change in Status" form whenever there has been a change in the participant's status that would affect their ability and/or willingness to participate in the program.
5. When applicable, make referrals to the local behavioral health (BH) agencies/providers and schedule a discharge planning meeting that includes the local BH team.
6. Assess what HOME Choice services should be added to the participant's ODM 02365 "HOME Choice Demonstration & Supplemental Services Plan" form at time of discharge, contact service providers, coordinate service provision and submit updated HOME Choice Demonstration & Supplemental Service Plans to the HOME Choice Operations Unit as necessary.
7. Assist participants with developing post-discharge back-up plans in the event of a failure of an authorized service to be provided.
8. Coordinate the participant's discharge date to coincide with the start of the participant's receipt of HCBS (waiver and/or state plan) and HOME Choice services.
9. Ensure that appropriate HOME Choice services are in place if waiver or state plan services cannot start at time of discharge.
10. Schedule and facilitate the final discharge planning meeting within two weeks prior to the participant's discharge from the institution. The following shall be invited and expected to attend the final discharge planning meeting:
 - a. The participant/guardian,
 - b. HOME Choice Case Manager,
 - c. HOME Choice Transition Coordinator,
 - d. Nursing Facility Social Worker/Discharge Planner,
 - e. Behavioral health providers if applicable,
 - f. HOME Choice service providers if applicable, and
 - g. Waiver providers if applicable
11. Ensure that either HCBS waiver case management or HOME Choice case management, as appropriate, is assigned to work with the participant prior to discharge. If HCBS waiver enrollment is pending, HOME Choice case management may be assigned.
12. Provide the discharge planning team with waiver status and waiver contact information if waiver enrollment is approved or pending.
13. Ensure that at the final discharge planning meeting, the discharge checklist is completed and that the discharge meeting's attendees sign off on assignments, coordinate final preparations for the participant's moving day, and agree on moving day participation and responsibilities.

E. At the time of the participant's discharge from the institution, the PTCM Agency shall:

1. Transfer all pertinent information (Including: ODM 02362 "HOME Choice-Informed Consent", ODM 02369 "HOME Choice Eligibility Checklist", HOME Choice Community Readiness Tool and updated ODM 02365 "HOME Choice Demonstration & Supplemental Services Plan") about the participant to either the HCBS Waiver Case Manager or the HOME Choice Case Manager, as appropriate.
2. Communicate and coordinate with the participant, the Transition Coordination Agency and the HCBS Waiver Case Manager or the HOME Choice Case Manager, as appropriate, to ensure services and supports are in place and housing is "move-in" ready.
3. Provide necessary assistance with moving which may include:
 - a. Helping the participant move out of the institution;
 - b. Being available to assist the participant at the participant's new home on move-in day.
4. Complete the ODM02368 "HOME Choice-Enrollment Request" and submit to the HOME Choice Operations Unit within 24 hours of the participant's discharge from the institution.
5. Submit an updated ODM 02365 "HOME Choice Demonstration and Supplemental Services Plan" form to the HOME Choice Operations Unit if additional HOME Choice services are needed post-discharge. The PTCM Agency shall contact service providers and coordinate service provision.

F. ODM, through its designee, shall pay the PTCM Agency for pre-transition case management services under this provider agreement as follows:

1. A payment of \$1,000.00 will be made to the PTCM Agency for each HOME Choice referral from ODM's HOME Choice Operations Unit that results in the initial face-to-face meeting. The expectation is that the PTCM Agency will complete the requirements described in paragraphs (A), (B) and (C) above. This payment of \$1,000.00 represents compensation for the PTCM Agency's completion of those requirements. In the event that the PTCM Agency does not complete the requirements described in paragraphs (A), (B) and (C), or if any payment under this provider agreement is made in error, ODM will recoup the payment by deducting the amount from a future payment.
2. A payment of \$1,000.00 will be made to the PTCM Agency for services performed during the pre-transition period including, at a minimum, those services identified in paragraph (D)(1) through (D)(5) above. This payment will be made upon ODM's HOME Choice Operations Unit's receipt of one of the following:
 - a. A completed ODM 02368 "HOME Choice-Enrollment Request" form ; or
 - b. A completed ODM 02371 "HOME Choice-Change in Status" form indicating the need for pre-enrollment termination along with documented evidence of the PTCM Agency having performed, at a minimum, the services identified in (D)(1) through (D)(5). This documentation must indicate the dates, times, location and service description of the specific PTCM work provided to the person after the initial face to face meeting.

G. The PTCM Agency agrees to comply with the terms of this provider agreement, along with federal and state laws, federal and state program requirements, and other requirements as required by ODM. The PTCM Agency also specifically agrees to:

1. Accept the allowable payments for pre-transition case management services as payment-in-full and not seek payment for the services from the resident/applicant, guardian, any member of the family, or any other person or entity.
2. Comply with data requests from ODM, including the provision of a complete data dictionary for electronic files.
3. Maintain all applicant/participant records necessary and in such form so as to fully disclose the extent of services provided for a period of six years from the date of payment based upon those records or until any initiated audit is completed, whichever is longer. At a minimum, each applicant/participant's record must contain:
 - a. A cover sheet that includes: name, address, and telephone number of the institution where the applicant resided, emergency contacts, guardianship information (if applicable), and name, address and phone number of the pre-transition case manager.
 - b. Case notes that include documentation of applicant/participant contacts and activities of the PTCM Agency on applicant's/participant's behalf. Nothing shall prohibit the use of technology-based systems in

collecting and maintaining case note documentation. All case notes must be signed and dated. (Electronic entry/submission constitutes verification of a signature.)

- c. Releases of information on HIPAA-compliant forms signed by the applicant/guardian.
 - d. Copies of the HOME Choice participant's service plans, forms, and any other documents related to the pre-transition process.
 4. Furnish to ODM, the secretary of the Department of Health and Human Services, or the Health Care Fraud Section of the Ohio Attorney General, or their designees, any information maintained under paragraph 3 above for audit or any other purpose within 30 days of the request for such information. Audits may use statistical sampling. Failure to comply shall result in withholding of HOME Choice Demonstration Program payments and may result in termination from the HOME Choice Demonstration Program.
 5. Inform the HOME Choice Operations Unit within thirty days of any changes to the information it provided in the Provider Enrollment Application / Time Limited Agreement (e.g., change in ownership and/or control; change in Medicaid number; change in address; new phone number; etc.).
 6. Have accurately disclosed in the application section on page two of this document PTCM ownership and control information, and the identity of any person with ownership or control interest (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX Services.
 7. Comply with the criminal record check requirements, as applicable, such as those set forth in 5160-45-07, 5160-45-08, 5123:2-2-01, and 173-39-03 of the Administrative Code.
 8. Ensure that staff providing direct participant contact:
 - a. Have knowledge about and experience with local community resources and applicable disability laws and regulations.
 - b. Embrace participant self-determination and possess experience advocating on behalf of individuals with disabilities.
 - c. Are eighteen years of age or older.
 9. Comply with the policies and procedures governing HOME Choice and the conditions of participation as set forth in Chapter 5160-51 of the Ohio Administrative Code.
 10. Have accurately disclosed in the application section of this document that neither the PTCM Agency, nor any owner, director, officer of the PTCM Agency, is currently subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.
- H. The HOME Choice Demonstration Program is not a Medicaid program. This agreement does not permit the PTCM Agency to furnish medical assistance services through the Ohio Medicaid Program.
- I. This agreement supersedes any and all previous provider agreements for this service, whether written or oral, between the parties.
- J. This agreement is intended to remain in effect for the duration of the HOME Choice Demonstration Program; however, the agreement may be terminated by either party upon written notice to the other party no less than 30 days prior to the termination date. The PTCM Agency, upon receipt of written notice of termination, shall immediately cease provision of services under this agreement unless otherwise directed by ODM.
- K. The PTCM Agency, including any officer, member, employee or agent of the PTCM Agency, understands and agrees to take no action, or cause ODM to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws, including those provisions found in Chapter 102 and Chapter 2921 of the Ohio Revised Code.
- L. The undersigned certifies that he/she is the officer, chief executive officer, or general partner of, or otherwise has legal authority to act on behalf of, the organization that is applying to provide pre-transition case management services as part of the HOME Choice Demonstration Program. The undersigned agrees to be bound by this Provider Enrollment Application / Time Limited Agreement, and confirms that the information he/she has provided is true and accurate.

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