

# HOME CHOICE: SUMMARY OF POST-TRANSITION ACTIVITIES

Participant Name:	
Participant Medicaid ID # (12 digits):	Participant Discharge Date (mm/dd/yyyy):
Transition Coordinator Name:	
Transition Coordination Agency/ HOME Choice Provider Number:	
Date of Contact:	
Type of Contact: <input type="checkbox"/> Face-to-Face <input type="checkbox"/> Phone	

## Expectations:

- This form is a checklist of items to review at every contact with the participant (Face-to-Face or phone) and one form, in its entirety, should be completed for each contact (n/a is not sufficient)
- The expectation is that the TC will continue to work with the individual to the 90<sup>th</sup> day in the community. Please submit all contact forms at the same time after the HOME Choice participant has reached 90 days in the community (between day 91-100)
- There must be a minimum of five contacts, including at least two face-to-face visits, during the first 90 calendar days after the participant's discharge. These five contacts are in addition to, and do not include, any visits or other interactions with the participant on or before the day that the participant moves into the community
- In cases where the participant returns to the hospital/nursing home/facility, the days in the facility do not count toward the 90 days post-transition

## Financial Discussion Prompts:

- Income/Social Security (Direct Deposit)
- Payee in place (if needed)
- Budgeting
- Bills paid in full
- Review need for CSC/ILST

Identify concerns & Follow-up plan:

## Housing Discussion Prompts:

- Confirm address & contact information
- Home modifications needed or completed
- Is housing safe and appropriate for needs (environmental checklist)
- Landlord/housing issues
- PIPP/HEAP needed/applied for
- HOME Choice emergency assistance used/needed?

Identify concerns & Follow-up plan:

<b>Benefits Discussion Prompts:</b>	
<input type="checkbox"/> Medicaid (Report discharge to county case worker, community Medicaid in place) <input type="checkbox"/> Spend down <i>Enrolled on a waiver:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If No, is a waiver application needed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> JFS benefits (food stamps, cash, etc.) <input type="checkbox"/> PRC funds	Identify concerns & Follow-up plan:
<b>Medical Discussion Prompts:</b>	
<input type="checkbox"/> Physician (appt/transportation) <input type="checkbox"/> Hospitalizations/ER visits <input type="checkbox"/> Medications <input type="checkbox"/> Durable medical equipment & supplies	Identify concerns & Follow-up plan:
<b>Behavioral Discussion Prompts:</b>	
<input type="checkbox"/> Mental Health Provider (appt/transportation) <input type="checkbox"/> Evidence of Drug/Alcohol abuse <input type="checkbox"/> Change in Behavior <input type="checkbox"/> Self-Care Concerns	Identify concerns & Follow-up plan:
<b>Community Discussion Prompts:</b>	
<input type="checkbox"/> Activities/Community inclusion <input type="checkbox"/> Volunteering/Employment/School <input type="checkbox"/> Peer support/Mentoring <input type="checkbox"/> Food resources <input type="checkbox"/> Emergency planning/Back-up plan <input type="checkbox"/> Legal Obligations (Parole etc.)	Identify concerns & Follow-up plan:
<b>Supports Discussion Prompts:</b>	
<input type="checkbox"/> Review HOME Choice service plan <input type="checkbox"/> Review other supports & services in place Are any additional services needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Identify concerns & Follow-up plan:

**Submit this Document to:**

**HOME Choice Operations Unit**

Ohio Department of Medicaid | Bureau of Long-Term Care Services and Supports

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