

# HOME Choice

## Service 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*

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# 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.

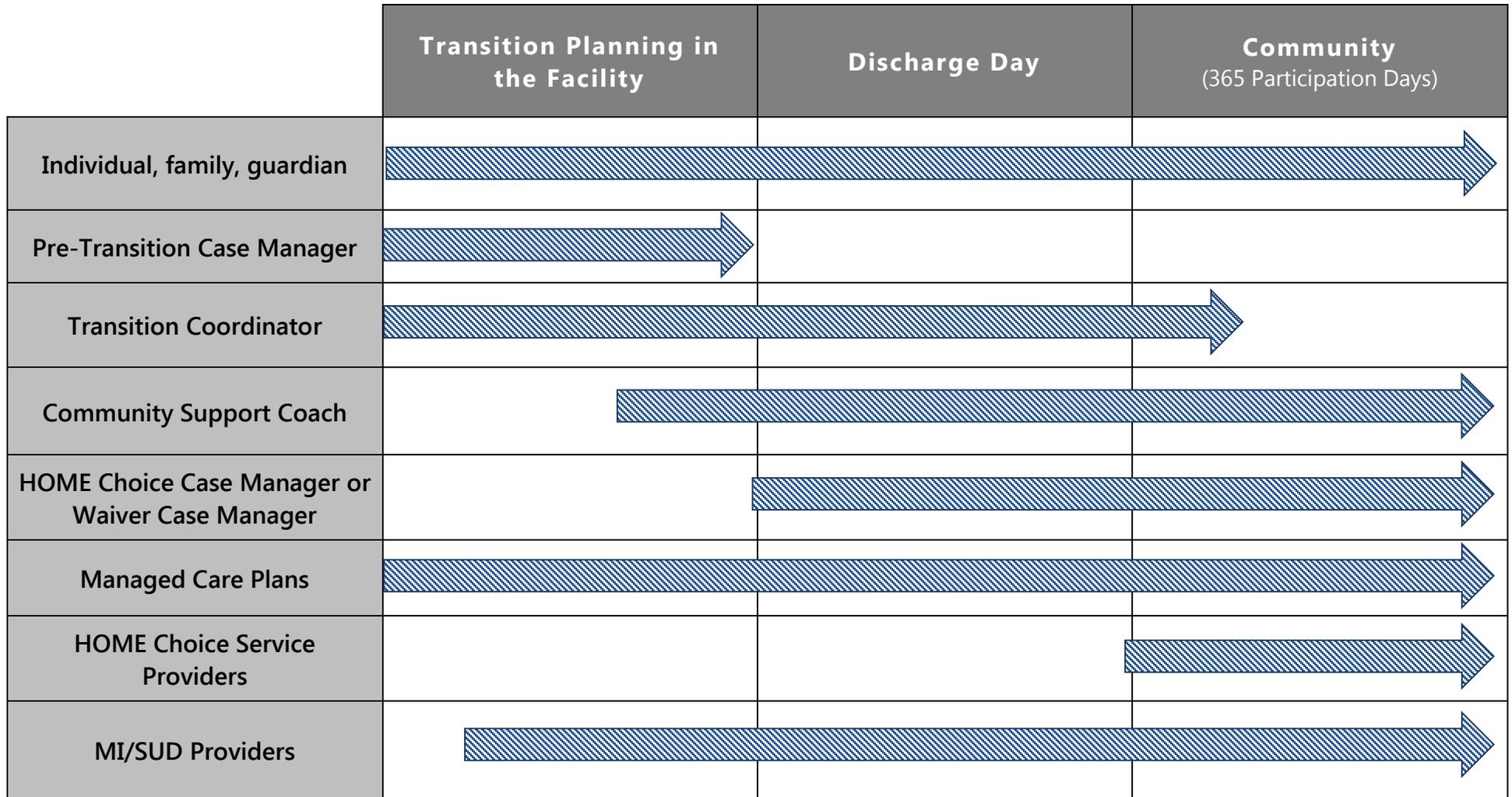
## **HOME Choice Eligibility Criteria for Individuals:**

- 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

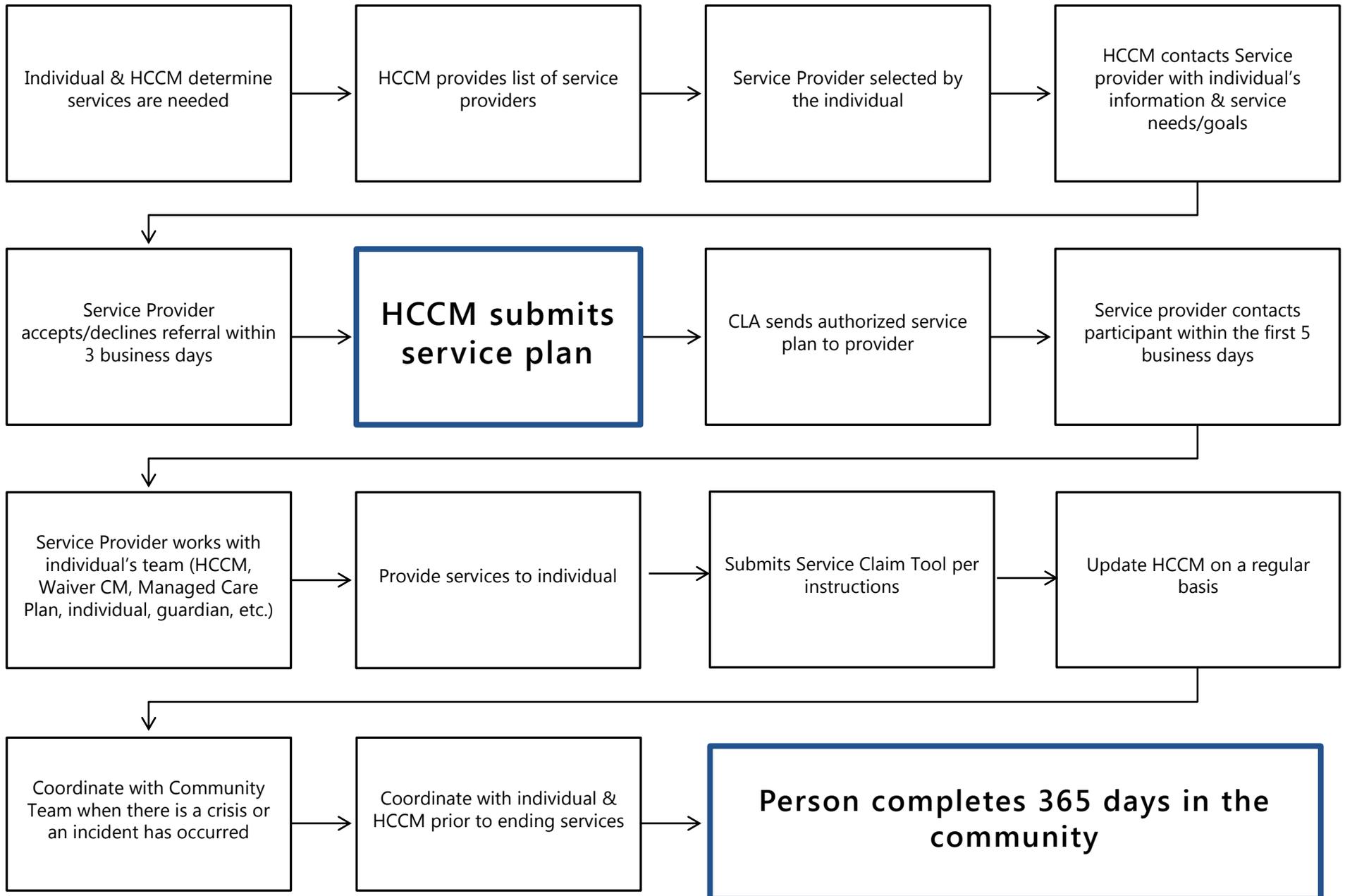
The purpose of this manual is to provide the tools, resources and expectations for HOME Choice Service Providers that will enable and empower you to provide value added services to Ohioans. Thank you for sharing the journey. Together, we are Making Ohio Better!

# Discharge Planning & Transition Team Overview

Below is a chart representing 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.



## Service Provider Flow Chart



# Service Needs Identified

## ► Service Provider Referral Process & Authorization

- The Case Manager will contact the service provider, share information, and identify service needs and goals for the individual.
- The provider has 3 business days to accept or decline to work with the individual.
- When accepted, the Case Manager will submit a service plan to HOME Choice Operations.
- Service Authorization with the service begin date will be sent to the provider from HOME Choice Operations. (Do not provide services until you receive an Authorized Service plan).
- Upon receipt of authorization the provider shall contact the HOME Choice individual within 5 business days.
- The provider will receive the Community Readiness Tool and the Eligibility Checklist as historical information regarding the individual.
- Additional information is provided by the case manager.

## ► Sample HOME Choice Service Authorization email (take note of highlighted section)

HOME Choice providers are only authorized to provide services for the date span (begin & end dates) indicated on the Service Plan. HOME Choice providers shall not provide services without receipt of an approved copy of the HOME Choice Service Plan designating them as the provider of that service. Unauthorized service dates submitted for payment will be returned unpaid. Contact the HOME Choice Case Manager if there are any questions.

**The anticipated completion date for this participant is 03/30/2016.**

This message was secured by **ZixCorp**©.

To reach ZixCorp, go to: <http://www.zixcorp.com/info/zixmail>

## ► Sample HOME Choice Service Plan (copy can be found in the Resources section)



Ohio Department of Medicaid  
**Demonstration and Supplemental Services Authorization**  
 For HOME Choice Services ONLY

Participant Name and Contact Information Name Address City, State, zip Phone: 123-456-7890 Guardian: Guardian Phone:		Medicaid #: <b>123456789123</b> Participant Start Date: 8/22/2013 (HC APPROVAL DATE) Participant End Date: CLA: Karen Jackson <b>1</b> Case Management Agency Name, Phone Number: CareStar, Bobbie Malone 456-789-0123 <b>2</b> Managed Care/MyCare Ohio Plan & phone number:		
Date(s) Begin and/or End date	HOME Choice Service Code	Span Units(s)	Cost	HC Provider Number/ Provider Name, Phone
8/2/2015 – 1/8/2016	HC018 – Pre-Transition Case Management	1	\$0.00	HC1609 – CareStar, Inc., 800-616-3718
9/4/2015 –	HC010 – Transition Coordinator	1	\$0.00	HC1501 – Jefferson Behavioral Health System,
1/8/2014 – 5/31/2014	HC015 – Home Choice Case Management	1	\$0.00	HC1611 – CareStar, Inc., 800-616-3718
1/14/2014 – <b>(3)</b>	HC003 – Independent Living Skills Training	576 <b>(4)</b>	\$0.00	HC1512 - Jefferson Behavioral Health
1/14/2014 – <b>(3)</b>	HC004 – Community Support Coaching	288 <b>(5)</b>	\$0.00	HC1512 - Jefferson Behavioral Health
1/14/2014 – <b>(3)</b>	HC005 – Social Work/Counseling Services	144 <b>(6)</b>	\$0.00	HC1512 - Jefferson Behavioral Health

**(1) Community Living Administrator**

**(2) Case Management Contact Information (Including phone number)**

**(3) Begin Date authorizing Service Providers**

**(4) Number of units authorized for Independent Living Skills Training (1-Unit = 15 minutes)**

**(5) Number of units authorized for Community Support Coaching (1-Unit = 15 minutes)**

**(6) Number of units authorized for Social Work Counseling (1-Unit = 15 minutes)**

- Services cannot begin prior to the Begin Date.
- Services cannot continue beyond the End Date.
- HCCM responsibility to contact service providers prior to Service Plan submission. Providers will receive additional documentation about the individual which may include: the Community Readiness Tool, Eligibility Checklist, and Enrollment Form.
- Providers receive updated service plans whenever they a revision is made by HOME Choice Operations.
- Community Support Coaching is the only service that may be authorized prior to discharge.

# Roles & Responsibilities of Service Providers

Providers should be familiar with the following resources that further identify roles, responsibilities and expectations of HOME Choice providers:

## ▶ Rule cites:

- Ohio Administrative Code 5160-51-01-03 "HOME Choice program conditions of participation and enrollment for provider";
- 5160-51-04 "HOME Choice program definitions of covered services and provider qualifications";
- 05160-51-06 "HOME Choice definitions of billing terms, reimbursement rates and billing procedures".

## ▶ Service Provider Agreement *(used in conjunction with the rules above)*

- Billing Information
- Documentation Requirements
- Service Delivery Information

## ▶ General Requirements of a Service Provider

- Annual BCI Criminal Records check requirement (for non-agency provider)
- Have a current and unrestricted license (for non-agency nurse, social work/counselor or nutritional consultation provider)
- Direct Staff Requirements
- Provider is not under sanctions for Medicaid or Medicare programs
- Abide by the Ohio code of Ethics
- Update HOME Choice with changes in ownership (agency provider)
- Update HOME Choice with phone number, street address and email address changes
- Attend trainings
- HIPAA Requirements and honoring confidentiality

## ▶ Conditions of Participation

- No behavior that causes or may cause physical, verbal mental or emotional abuse to the individual
- Cannot be designated as an authorized rep, Payee, POA or guardian or designated on any bank accounts or credit cards
- No accepting of money or anything of value
- Must not take individual to the service provider's home or take children, pets or friends to the individual's home
- Cannot deliver services while individual hospitalized, institutionalized or incarcerated

# Service Delivery of Providers

## ► Information about Service Delivery

- Delivered in a prompt and professional manner
- HC is not Medicaid and cannot deliver Medicaid services
- Delivered according to the Service Plan
- Rendered by the provider and not sub-contracted without the prior written consent of ODM
- Follow incident reporting requirements

## ► What do I do when?

*You will encounter situations where the individual may be in distress or facing a crisis such as:*

- Individual has no food
- Individual has been abusing substances
- Individual received an eviction notice
- Individual is out of medication
- Individual was hospitalized due to diabetes or some medical complication
- Individual is having trouble paying bills, managing a budget and is behind on rent, utilities, etc.
- Individual states they are hearing voices, having suicidal thoughts, or a threat to self or others.

## ► On-going Communication with the Case Manager

- Routine communication
  - Before first visit
  - Regular intervals
- Non-routine Reasons
  - Incident of any type
  - Moved to another address or location is unknown
  - Money/bill paying issues
  - Declines your service consistently
  - Hospitalized or ER visits
  - Health, welfare and/or safety issues
  - Environmental conditions affecting the individual

## ► Ongoing Services & Communication

*Professional expectations of a service provider:*

- Respond in a prompt and professional manner.
- Embrace the individual's self-determination.
- Do not accept any money or anything of value from the individual or their home.
- Do not take the individual to your home or bring children, friends, or pets to the individual's home.
- Respond to crisis situations accordingly.
- Facilitate open and honest communication with all parties involved.

► **Provider Documentation** (Provider agreement & rule 5160-51-03)

- HOME Choice does not have a specific form for providers to use, however:
  - All providers shall maintain a separate file per individual for six years from date of receipt that will include:
    - Copy of the service plan with provider authorization
    - Chronological records of contacts with individual or on behalf of the individual:
      - Notes with dates & signatures
      - Description of what took place (what); location (where); and with whom
      - Any other documents related to services delivered
      - Dates of service with begin and end times
      - Signature of both the provider and the individual validating the service was provided
      - Provider name and HC provider #, address, phone number
    - Copies of billing submitted to fiscal management agency
- When and why might we ask for your documentation? Based on an incident report, a billing inquiry, or an alleged complaint received.
- Submit to ODM within 30 days in case of an audit
- It is the provider's responsibility to monitor "units/claims" billed in order not to exceed the cap.

# Community Transition Funding Information

## ► Goods & Services Funds

- Goods & Services Funds are **startup** funds available for items such as:
  - Security deposit & 1<sup>st</sup> month's rent
  - The purchase of furniture & household goods
  - Clothing and groceries **at the time of transition**
- 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 Coordination and service providers must explore all community-based charitable resources before requesting the use of any funds.
- All requests are subject to the approval of HOME Choice Operations.
- Link to Counties who have Prevention, Retention and Contingency (PRC) Plans:  
<http://jfs.ohio.gov/owf/prc/county/countystate.stm>

## ► Emergency Rent & Utility Assistance

Emergency rental and utility assistance may be available post-discharge when necessary to prevent re-institutionalization. These services are available to cover circumstances, out of the control of the participant, that prevent the participant from paying rent/utilities and are needed to assure health and welfare. These funds must be approved prior to their being accessed.

Requests should be made through the Case Manager and/or the Transition Coordinator who will email HOME Choice Operations with the required form. They must describe in detail the reasons behind the need for emergency rental and utility assistance and a plan for ensuring that another emergency request will not be needed for this participant. A request may not exceed \$650.00 per month nor may it continue for more than nine (9) months of the consumer's 365 day demonstration period. Once the service is approved, it is the responsibility of the Transition Coordinator to submit check requests to the fiscal management service for payment.

# Incident Reporting

Any incident discovered during a contact/visit should be reported by the Provider to the case manager immediately. The HOME Choice individual may have a HOME Choice case manager through Care Star or a case manager by a waiver agency or MyCare plan. The waiver case management agency or the plan contact information is identified on the upper right hand corner of the individual's service plan. The case manager needs to create and submit an incident report **within twenty-four hours of discovery**. Rule 5160-51-03 (found in the appendix) outlines the expectation for all providers.

## ► What is an incident?

An **incident** is a situation that may cause harm, have the potential to cause harm or has caused harm to an individual. They are alleged, suspected or actual events that are not consistent with routine care or routine service delivery.

### Incidents include the following:

ABUSE*	LOSS OF INCOME
ACCIDENT/INJURY	MEDICATION ADMINISTRATION ERROR
BACK-UP PLAN FAILURE	NEGLECT*
DEATH	NURSING FACILITY READMISSION
ENVIRONMENTAL EMERGENCY	OTHER
EXACERBATION OF HEALTH PROBLEMS	SENTENCED TO JAIL OR PRISON
EXPLOITATION*	SUBSTANCE ABUSE/OVERDOSE
HOSPITALIZATION	SUICIDAL THOUGHTS/ATTEMPTS
INAPPROPRIATE SERVICES/UNMET NEED	THEFT OF INDIVIDUAL'S MEDICATION
INVOLVEMENT WITH CRIMINAL JUSTICE SYSTEM	THEFT OF INDIVIDUAL'S MONEY
LOCATION UNKNOWN	THEFT OF INDIVIDUAL'S PERSONAL PROPERTY
LOSS OF CAREGIVER	VICTIM OF A CRIME, OTHER
LOSS OF HOUSING	

*A full list of incident types and their definitions can be found in the Appendix.*

## ► Incident Process Actions:

- Immediate measures must be taken to assure the health and welfare of the individual which may include:
  - Emergency medical attention for the individual.
  - Contact law enforcement for safety strategies.
  - Contacting the individual's family or other support persons.
- Once the provider feels the individual's safety has been assured, the provider needs to gather as much incident information as possible from all parties involved including the individual.
- *Nurses and social workers are mandated reporters, and must adhere to a legal standard for reporting abuse, neglect or exploitation as required by their licensure which may include reporting to Adult Protective Services and/or Children's Protective Services.*
- Contact the case manager and provide at minimum the following:
  - Identity and demographic information of the individual
  - Description of the incident with date and time
  - Names of others involved
  - Immediate actions taken to protect the individual
  - Details for reports made to protective agencies
  - Name and contact information for the service provider sharing the incident information
  - All other pertinent information
- Be available to supply further incident information and to participate in the prevention planning process

# Forms & Fiscal Management Agency Information

## ► Change in Status Form (copy can be found in the Resources section)

- This is an important communication tool for monitoring the status of individuals.
- A CIS form must be submitted as soon as there is knowledge of a change in the individual's status or address.

Examples include:

- individual has moved
- individual has been hospitalized
- individual has been re-institutionalized
- individual has been incarcerated
- individual has died

- Submit to HOME Choice Operations via email or fax as indicated on the form
- Notify the case manager of the situation via phone call and/or email them the CIS form

Ohio Department of Medicaid  
**HOME CHOICE - CHANGE IN STATUS**

Participant Name (Last, First, MI) _____		Medicaid ID # (12 digits) _____	
<b>Section 1: PRE-ENROLLMENT TERMINATION</b> <i>Complete Section 1 only if participant terminates or withdraws before enrollment into the program.</i>			
Effective Date (mm/dd/yyyy) _____			
Reason (Check one below.)			
<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 (You must specify.) _____		
<b>Section 2: INSTITUTIONALIZATION OR TRANSFER FROM ONE FACILITY TO ANOTHER AFTER ENROLLMENT</b> <i>Complete Section 2 only if participant is admitted to a facility after enrollment into the program.</i>			
Admission from <input type="checkbox"/> Residence <input type="checkbox"/> Another Institution			
Admission Date (mm/dd/yyyy) _____			
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 (Specify.) _____			
Reason for Institutionalization (Check one.)			
<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		
<b>Section 3a: RESIDENCE INFORMATION</b> <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 <input type="checkbox"/> Discharge from Facility <input type="checkbox"/> Change in Residence		Effective Date (mm/dd/yyyy) _____	
Current Phone # (xxx-xxx-xxxx) _____		Residence Address _____	
City _____		County _____	State _____
		Zip _____	
Is participant living with family? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Participant Name (Last, First, MI) _____		Medicaid ID # (12 digits) _____	
<b>Section 3b: RESIDENCE TYPE</b> <i>Complete both parts of section 3b when participant moves from one qualified residence to another or is discharged from a facility.</i>			
IS THE RESIDENCE			
<input type="checkbox"/> 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			
<input type="checkbox"/> A home owned/rented by the participant			
<input type="checkbox"/> A home owned/rented by a family member or friend			
<input type="checkbox"/> An apartment/house leased by the participant (not assisted living)			
<input type="checkbox"/> 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 (Describe.) _____		
<input type="checkbox"/> Not Applicable			
<b>Section 4: DISENROLLMENT FROM HOME CHOICE</b> <i>Complete only if participant terminates the program after enrollment.</i>			
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 (You must specify.) _____		<input type="checkbox"/> Loss of Medicaid	
<b>Section 5: COMPLETED BY</b>			
Name _____		Agency _____	Phone _____
		Ext _____	
<p><b>Send completed form to:</b> HOME Choice Operations Unit Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports PO Box 182709, 5<sup>th</sup> Floor Columbus, OH 43218-2709</p> <p>Email: HOME_Choice@medicaid.ohio.gov Fax Number: 614-466-6945</p>			



# HOME Choice Community Services

## ▶ As a **COMMUNITY SUPPORT COACH** I am responsible for:

- Providing *peer support*.
- Assisting individual with *setting goals* to become more independent.
- Teaching the individual how to *manage multiple tasks*.
- Teaching how to *solve problems* independently.
- Identifying *community resources*
- Assisting with *job searching*
- And so much more....

## ▶ As an **INDEPENDENT LIVING SKILLS TRAINING SPECIALIST** I am responsible for:

- Focusing on Community Living Skills. Some examples include:
  - Home management skills (shopping, meal planning, housekeeping, laundry, etc.)
  - Money management skills (bill paying, banking, etc.)
  - Managing transportation (buses/other community transportation options, educating and training on how to access, etc.)
  - Knowing how to ask for help
  - Finding a job

## ▶ As a **NURSING PROVIDER** I am responsible for:

- Providing intermittent RN or LPN services under supervision of an RN
- Providing services within the nurse's scope of practice
- Maintaining clinical records (All plans of care; type/frequency/scope/duration of services; documentation of MD orders)

## ▶ As a **NUTRITIONAL CONSULTATION PROVIDER** I am responsible for:

- Provides individualized guidance
- Develop a nutritional intervention plan with the individual, case manager, physician, etc.
- Maintaining clinical records

## ▶ As a **SOCIAL WORK/COUNSELING PROVIDER** I am responsible for:

- Helping to develop a stable & supportive environment
- Promoting the individual & family member's physical, social and emotional well-being.
- Conducting a psycho-social assessment that includes financial & environmental status
- Crisis intervention, grief counseling
- Developing a treatment plan that is shared with the individual and case manager

## ▶ As a **COMMUNICATION AID PROVIDER** I am responsible for:

- Communication devices to assist with hearing, speech or vision impairments
- Other mechanical and electronic devices
- Interpreter services that can include electronic device
- New technologies and devices that meet the individuals needs

## ▶ As a **SERVICE ANIMAL PROVIDER** I am responsible for:

- Ensuring the animal is trained to perform tasks that the individual cannot perform themselves:
- Service can assist with expenses associated with the animal, including: housing, upkeep & medical care; equipment & supplies; or transportation to the vet

## ▶ As **RESPITE PROVIDER** I am responsible for:

- The general supervision of the individual who is not able to care for themselves due to the temporary absence of the primary caregiver.
- The following respite services may be provided: in-home, out-of-home, day camp setting, and assisting with housekeeping chores/meal preparation/shopping

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# APPENDIX

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# 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](mailto:HOME_CHOICE@medicaid.ohio.gov) or by **FAX** to (614) 466-6945

IF YOU NEED:	CONTACT:
<p><b>Basic Information</b> on the HOME Choice program, <b>questions</b> on status of applications, <b>updates</b> to provider contact information, <b>assistance</b> with provider applications, <b>website</b> information, etc.</p>	<p><i>Administrative Assistant:</i>  <b>Angela Walls</b>            Call: 1-888-221-1560            Email: <a href="mailto:Angela.Walls@medicaid.ohio.gov">Angela.Walls@medicaid.ohio.gov</a></p>
<p><b>Intake Coordinators</b> process the HOME Choice applications and referrals, provide technical assistance and support.</p>	<p><i>Intake Coordinators:</i>  <b>Daniel Hageman</b>  <b>Bonnie Hubbard- Nicosia</b>            Call: 1-888-221-1560            Email: <a href="mailto:HOME_Choice@medicaid.ohio.gov">HOME_Choice@medicaid.ohio.gov</a></p>
<p><b>HOME Choice Caseload for children age 21 and under</b> (e.g. case specific inquiries, service planning, technical assistance for population type, or Medicaid services both waiver or non-waiver)</p>	<p><i>Community Living Administrator:</i>  <b>Jessica Hawk</b>            Call: (614) 752-3516            Email: <a href="mailto:Jessica.Hawk@medicaid.ohio.gov">Jessica.Hawk@medicaid.ohio.gov</a></p>
<p><b>HOME Choice Caseload for persons age 22 through 59 with physical disabilities</b> (e.g. case specific inquiries, service planning, technical assistance for population type, or Medicaid services both waiver or non-waiver)</p>	<p><i>Community Living Administrator:</i>  <b>Laurie Damon</b>            Call: (614) 752-3576            Email: <a href="mailto:Laurie.Damon@medicaid.ohio.gov">Laurie.Damon@medicaid.ohio.gov</a></p>
<p><b>HOME Choice Caseload for persons age 22 and older with primary mental health needs and/or substance use disorders</b> (e.g. case specific inquiries, service planning, technical assistance for population type, or Medicaid services both waiver or non-waiver)</p>	<p><i>Community Living Administrators:</i>  <b>Karen Jackson</b>            Call: (614) 752-3789            Email: <a href="mailto:Karen.Jackson@medicaid.ohio.gov">Karen.Jackson@medicaid.ohio.gov</a>  <b>Joni Janowiak</b>            Call: (614) 752-3016            Email: <a href="mailto:Joni.Janowiak@medicaid.ohio.gov">Joni.Janowiak@medicaid.ohio.gov</a></p>
<p><b>HOME Choice Caseload for persons age 60 and over and for persons age 22 and older with developmental disabilities</b> (e.g. case specific inquiries, service planning, technical assistance for population type, or Medicaid services both waiver or non-waiver)</p>	<p><i>Community Living Administrator:</i>  <b>Yvette Weaver</b>            Call: (614) 752-3555            Email: <a href="mailto:Yvette.Weaver@medicaid.ohio.gov">Yvette.Weaver@medicaid.ohio.gov</a></p>
<p><b>Provider Administration</b> (e.g. Provider Training, Technical Assistance, Criteria, Provider Communications, Website, Forms, Billing/Payment questions, etc.)</p>	<p><i>Provider Administrator:</i>  <b>Brock Robertson</b>            Call: (614) 752-3577            Email: <a href="mailto:Brock.Robertson@medicaid.ohio.gov">Brock.Robertson@medicaid.ohio.gov</a></p>
<p><b>Provider Oversight &amp; Compliance</b> (e.g. Protection from Harm/Incident Reporting, Technical Assistance for Managed Care/MyCare, Education, Compliance Reviews, etc.)</p>	<p><i>Provider Oversight &amp; Compliance:</i>  <b>Carol Schenck</b>            Call: (614) 387-7755            Email: <a href="mailto:Carol.Schenck@medicaid.ohio.gov">Carol.Schenck@medicaid.ohio.gov</a></p>
<p><b>Minimum Data Set - Section Q (Community Living Specialists)</b> (e.g. Referrals, technical assistance, criteria, invoicing, training, CLPA web application, MDS reports, Quality of Life Survey contract &amp; reports, etc.)</p>	<p><i>MDS Section Q Manager:</i>  <b>Becky Kuhn</b>            Call: (614) 752-3554            Email: <a href="mailto:Rebecca.Kuhn@medicaid.ohio.gov">Rebecca.Kuhn@medicaid.ohio.gov</a></p>

<p><b>MFP Project Director and HOME Choice Operations</b> (e.g. Program oversight and administration, policy review, customer service issues, manage operations workflow and HOME Choice staff, general inquiries, budget and policy, etc.)</p>	<p><i>MFP Project Director:</i>  <b>Jane Black</b>  Call: (614) 752-3567  Email: <a href="mailto:Jane.Black@medicaid.ohio.gov">Jane.Black@medicaid.ohio.gov</a></p>
<p><b>Provider Claims, Billing issues, Process, Questions regarding payment, Website Portal, etc.</b></p>	<p><b>Morning Sun Financial Management Services</b>  <a href="http://www.morningstarfs.com/">http://www.morningstarfs.com/</a></p>
<p><b>Housing Assistance</b> for questions for HOME Choice or otherwise</p>	<p><i>Housing Coordinators:</i>  <b>Emily VanBuren</b>  Call: (614) 752-3805  Email: <a href="mailto:Emily.VanBuren@medicaid.ohio.gov">Emily.VanBuren@medicaid.ohio.gov</a>  <b>Jeannette Welsh</b>  Call: (614) 752-3406  Email: <a href="mailto:Jeannette.Welsh@medicaid.ohio.gov">Jeannette.Welsh@medicaid.ohio.gov</a></p>
<p><b>HOME Choice Data Reporting, Analysis, Database Management</b>  (e.g. Federal reporting, data projects, data integration and analysis, etc.)</p>	<p><i>HOME Choice Information Manager:</i>  <b>Eric Mundy</b>  Call: (614) 752-3826  Email: <a href="mailto:Eric.Mundy@medicaid.ohio.gov">Eric.Mundy@medicaid.ohio.gov</a></p>
<p><b>MFP liaison for MHAS &amp; Recovery Requires a Community</b> (e.g. Training, Resources, HOME Choice provider assistance with Recovery Requires a Community, Community Transitions &amp; RSS resource)</p>	<p><i>MFP Mental Health &amp; Addiction Services Liaison:</i> <b>Ellie Jazi</b>  Call: (614) 466-6783  Email: <a href="mailto:Recovery@mha.ohio.gov">Recovery@mha.ohio.gov</a>  Email: <a href="mailto:ellie.jazi@mha.ohio.gov">ellie.jazi@mha.ohio.gov</a></p>
<p><b>MFP liaison for DODD</b> (e.g. Training for county boards/providers, Technical Assistance, DC, IID/ICF community transitions)</p>	<p><i>MFP Developmental Disabilities Liaison:</i>  <b>Sara Lawson</b>  Email: <a href="mailto:Sara.Lawson@dodd.ohio.gov">Sara.Lawson@dodd.ohio.gov</a>  HOME Choice website link to DD training:  <a href="http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice/TrainingUpdates.aspx">http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice/TrainingUpdates.aspx</a></p>
<p><b>SUCCESS Project</b> for 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><i>SUCCESS Project Coordinator:</i>  <b>Laurie Damon</b>  Call: (614) 752-3576  Email: <a href="mailto:Laurie.Damon@medicaid.ohio.gov">Laurie.Damon@medicaid.ohio.gov</a></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](#)

## B. Roles and Responsibilities Chart: HCCM vs. CSC vs. ILST

	HOME Choice Case Management	Community Support Coach	Independent Living Skills Training
<b>What is the service?</b>	Support by working with the individual collaboratively to help review, plan, assist, and advocate for options and services that best meet the needs of the individual in the	Support for community living by one-on-one coaching that guides, educates and empowers HOME Choice individuals and their families.	Training develops or increases skills, knowledge and abilities needed to successfully live on one's own.
<b>When is the service provided?</b>	May start prior to discharge in order to participate in discharge planning and on the day of discharge. Service begin date is based on authorization by HOME Choice Operations. HCCM continues throughout the 365 days of participation.	<b>Before, during</b> and <b>after</b> a move to the community	During the 365 day participation period
<b>How is the service provided?</b>	Individuals not on a waiver will be authorized HCCM who will meet with and contact the individual on a regular basis.	One-on-one with the participant and/or their family	Training services can be delivered to an individual or in a group or classroom setting
<b>What type of help is provided?</b>	<p><b>Pre-Transition:</b></p> <ul style="list-style-type: none"> <li>• Discharge planning meeting</li> <li>• Responsibilities on day of discharge</li> <li>• Determine post-discharge HOME Choice and state plan services</li> <li>• Ensure HC services are in place if waiver or state plan services cannot start at discharge</li> </ul> <p><b>Day of Discharge:</b></p> <ul style="list-style-type: none"> <li>• Be available and present for assistance and support on moving day</li> <li>• Provide 24 hour contact information and documentation of a backup plan for participant</li> </ul> <p><b>Community Activities:</b></p> <ul style="list-style-type: none"> <li>• Maintain contact with service providers</li> <li>• Assess if additional services are needed</li> <li>• Maintain contact with the individual monthly</li> <li>• Facilitate at least one post-discharge meeting with TC, individual, and other providers within the first 80 days of discharge</li> <li>• Responsible for incident reporting</li> <li>• Assist individual with housing recertification and rental assistance</li> <li>• Inform all service providers when participant is within 30 days of completing his 365 day participation period.</li> <li>• Facilitate final meeting with individual, and providers prior to 365 participation period is complete</li> </ul>	<p><b>Financial management skills:</b></p> <ul style="list-style-type: none"> <li>• Assisting with employment goals</li> <li>• Evaluating employment skills/potential</li> <li>• Developing job finding strategies</li> <li>• Increasing interview skills</li> <li>• Developing application and resume writing</li> </ul> <p><b>Improving social skills:</b></p> <ul style="list-style-type: none"> <li>• Making educated choices</li> <li>• Evaluating options and consequences</li> <li>• Accepting responsibility for decisions</li> </ul> <p><b>Health management skills:</b></p> <ul style="list-style-type: none"> <li>• Setting health goals</li> <li>• Making informed health decisions</li> <li>• Accepting health responsibilities</li> <li>• Evaluating health options and strategies</li> <li>• Responsibility for recovery services goals</li> </ul> <p><b>Home management skills:</b></p> <ul style="list-style-type: none"> <li>• Finding new and different ways to do things</li> <li>• Developing problem solving strategies</li> <li>• Learning to break projects down into tasks</li> </ul> <p><b>Personal skills training:</b></p> <ul style="list-style-type: none"> <li>• Developing strategies to obtain goals</li> <li>• Creating short and long range goals</li> </ul> <p><b>Community living skills:</b></p> <ul style="list-style-type: none"> <li>• Investigating community resources</li> <li>• Anticipating and planning for future needs</li> </ul>	<p><b>Financial management skills:</b></p> <ul style="list-style-type: none"> <li>• Finding a bank and setting up an account</li> <li>• Paying bills and taxes</li> <li>• Creating and sticking to a budget</li> <li>• Using a bank (ATM) machine</li> </ul> <p><b>Improving social skills:</b></p> <ul style="list-style-type: none"> <li>• How to be a good neighbor and/or roommate</li> <li>• When and how to ask for help</li> </ul> <p><b>Health management skills:</b></p> <ul style="list-style-type: none"> <li>• Nutrition: what to eat, how much to eat, when and how often</li> <li>• How to talk to the doctor</li> <li>• Managing and accessing medical supplies</li> <li>• Crisis care/recovery services</li> <li>• How to link to doctors and dentists</li> <li>• Learning about &amp; getting devices that help the individual live independently</li> <li>• Preparing for emergencies</li> <li>• Learning how and when to take medicine</li> </ul> <p><b>Home management skills:</b></p> <ul style="list-style-type: none"> <li>• Personal shopping</li> <li>• Housekeeping and laundry</li> <li>• Grocery shopping, cooking and meal planning</li> <li>• How to use appliances</li> </ul> <p><b>Personal skills training:</b></p> <ul style="list-style-type: none"> <li>• Dressing and bathing</li> <li>• Making and keeping appointments</li> </ul> <p><b>Community living skills:</b></p> <ul style="list-style-type: none"> <li>• How to read a bus schedule, call for transportation</li> <li>• Identifying and accessing community resources</li> <li>• Safety skills in the community</li> </ul>

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

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

## D. Provider Rate Chart

### NURSING

Billing code	Service	Base rate	Unit rate	Maximum hours per month
HC001	HOME choice nursing provided by an RN	\$ 56.65	\$ 5.87	44 hours per month
HC002	HOME choice nursing provided by an LPN	\$ 56.65	\$ 5.87	44 hours per month

### SERVICES

Billing code	Service	Billing unit	Max. rate	Unit rate	Maximum usage amounts
HC003	Independent living skills training	15 minutes	\$ 30.00 per hour	\$ 7.50	144 hours during the 365-day demonstration period
HC004	Community support coaching	15 minutes	\$ 25.00 per hour	\$ 6.25	72 hours during the pre-transition and 365-day demonstration periods, combined
HC005	Social work/counseling services	15 minutes	\$ 64.12 per hour	\$ 16.03	36 hours during the 365-day demonstration period
HC006	Nutritional consultation services	15 minutes	\$ 52.56 per hour	\$ 13.14	36 hours during the 365-day demonstration period
HC007	Communication aids	Per item	A maximum of \$5,	N/A	\$5,000 during the 365-day demonstration period
HC008	Service animals	Per item	A maximum of \$8,	N/A	\$8,000 during the 365-day demonstration period
HC009	Community transition services	Per item	A maximum of \$2, 500.00 for all items (included in this is a maximum of \$500 for pre-transition transportation expenses)	N/A	A maximum of \$2,500 for all items (included in this is a maximum of \$500 for pre-transition transportation expenses, and for all other approved community transition services, a maximum of \$2,000 during the pre-transition and 365-day demonstration periods, combined)
HC012	In-home respite services	15 minutes	\$ 9.00 per hour	\$ 2.25	\$2,000 for in-home, out-of-home and camp respite services, combined, during the 365-day demonstration period
HC013	Out-of-home respite services	Per day with overnight stay	\$ 200.00 per day	N/A	\$2,000 for in-home, out-of-home and camp respite services, combined, during the 365-day demonstration period
HC014	Camp respite services	Per day	A maximum of \$625 per week	\$125	\$2,000 for in-home, out-of-home and camp respite services, combined, during the 365-day demonstration period, and including a maximum of \$625/week for camp respite

## E. Incident Types Definitions

**Abuse\*\*** –includes any of the following;

Emotional Abuse – Action towards an individual which results in the individual feeling threatened, coerced, intimidated, harassed or humiliated.

Physical Abuse – Physical force resulting in physical harm or which could reasonably be expected to have resulted in physical harm.

Sexual Abuse – Unwanted sexual activity of any type towards an individual; sexual conduct toward an Individual who is incapable of providing consent.

Verbal Abuse – Words or gestures toward an Individual used to threaten, coerce, intimidate, harass or humiliate the Individual.

**Accident/Injury** - Any unanticipated accident, injury or fall that results in the need for the individual to go to the hospital, ER, Urgent Medical Center or physician for assessment and/or treatment.

**Back-up Plan Failure** - Person(s) identified as available to provide services in the event regular paid providers are unable/unavailable or fails to provide crucial support to the individual.

**Death\*** - The death of an individual for any reason.

**Environmental Emergency (power outage, fire, flood, etc.)\*** – An unanticipated environmental event that results in a disruption of the individual's living situation.

**Exacerbation of Health Problems** – An increase in the severity of a disease or its signs and symptoms.

**Exploitation \*\***– Person using an individual for their own profit or advantage, or the use of the individual's money and/or property for personal benefit or gain.

**Hospitalization\*** – An individual is admitted to a hospital or in-patient hospice facility. Planned hospitalizations are not considered incidents.

**Inappropriate Services/Unmet Need** – Services that are provided and are inappropriate for meeting an individual's need or services are not in place to meet an identified need.

**Involvement with Criminal Justice System** – Involvement with the criminal justice system either as a witness to a crime or involved in actual criminal activity.

**Location Unknown\*** - The individual's whereabouts are unknown. Individual is missing.

**Loss of Caregiver** – Loss of individual's community caregiver that impacts the individual's ability to remain in the community or reasonably could be expected to adversely affect the individual's health and safety.

**Loss of Housing \***- The individual is rendered homeless, or when the individual has received an eviction notice.

**Loss of Income** – The individual's primary source of income has ended, either through unemployment or ineligibility.

**Medication Administration Error** – Medication not administered in the amount, form, and/or timeframe prescribed by the physician by a nurse or a person appointed by the individual to assist with medications. Self-administration of medications that are not in the amount, form and/or timeframe prescribed by the physician that result in illness and/or injury that requires medical intervention.

**Neglect\*\*** – Action or inaction that did, or reasonably could have been expected to, adversely affect the individual's health and/or safety.

**Nursing Facility Readmission\*** - Institutional readmission. Readmission could be to a NF, ICF, AL (that is not a HOME Choice Qualified Residence) or a Residential Treatment Facility.

**Other\*** – Used for ER visits, individual’s behavior which creates significant community living difficulties, a decline in the individual’s mental health status, or other issues that create or result in significant problems that are not covered by a different category.

**Sentenced to Jail/Prison** – Individual has been sentenced by a judge to serve time in a jail/prison facility. Also, if an individual is court ordered to participate in residential treatment for alcohol or substance abuse.

**Substance Abuse/Overdose** – The accidental or intentional use of a drug or medicine in an amount that is higher than is normally used or the use of illegal substances. All drugs have the potential to be misused, whether legally prescribed by a doctor, purchased over-the-counter or bought illegally. Taken in combination with other drugs or with alcohol, drugs normally considered safe can lead to long term serious consequences or death.

**Suicidal Thoughts/Attempts** – Individual communicates a desire to take his/her life, or attempts to take his/her life.

**Theft of Individual’s Medication** – Evidence that individual’s medication is unaccounted for; suspicion by individual, or other party that a particular person or an unidentified person is stealing or has stolen individual’s medication.

**Theft of Individual’s Money** – Evidence that individual’s money is unaccounted for; suspicion by individual, or other party that a particular person or an unidentified person is stealing or has stolen individual’s money.

**Theft of Individual’s Personal Property** – Evidence that individual’s personal property is unaccounted for; suspicion by individual, or other party that a particular person or an unidentified person is stealing or has stolen individual’s personal property.

**Victim of a Crime, Other** - The individual is the victim of an illegal action in a way not captured by another category.

\* Submission of a *Change in Status form* (CIS) may be necessary to inform the HOME Choice Operations Unit of the Individual’s current status.

\*\* Nurses, social workers and mandated reporters must adhere to a legal standard for reporting abuse, neglect and exploitation as required by their licensure which may include reporting to Adult Protective Services and/or Children’s Protective Services.

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## 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 changes.

**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](#)

### ► HOME CHOICE TOOLS

- [Case Manager Checklist](#)
- [Combined Residence Verification and Security Deposit and 1st Month Rent Document](#)
- [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 Who's Who](#)
- [Housing Navigation Request](#)
- [Morning Sun Financial Services Website](#)
- [Move-In Ready Checklist](#)
- [Payment Request Tool](#)
- [Recovery Requires a Community Website](#)
- [Service Claim Tool](#)
- [Summary of Post-Transition Activities](#)
- [TC Provider Manual](#)
- [TC Planning Document / To-Do Checklist](#)
- [TC Relocation Workbook](#)
- [Transportation Funds Guidelines](#)

## B. Mock Service Plan



Ohio Department of  
Medicaid  
**Demonstration and Supplemental Services  
Authorization  
For HOME Choice Services  
ONLY**

Participant Name and Contact Information Name Address City, State, zip Phone: 123-456-7890 Guardian: Guardian Phone:		<b>Medicaid #: 123456789123</b> Participant Start Date: 8/22/2013 <b>(HC APPROVAL DATE)</b> Participant End Date: CLA: Karen Jackson <b>(1)</b> Case Management Agency Name, Phone Number: CareStar, Bobbie Malone 456-789-0123 <b>(2)</b> Managed Care/MyCare Ohio Plan & phone number:		
Date(s) Begin and/or End date	HOME Choice Service Code	Span Units(s)	Cost	HC Provider Number/ Provider Name, Phone
8/2/2015 – 1/8/2016	HC018 – Pre-Transition Case Management	1	\$0.00	HC1609 – CareStar, Inc., 800-616-3718
9/4/2015 –	HC010 – Transition Coordinator	1	\$0.00	HC1501 – Jefferson Behavioral Health System,
1/8/2014 – 5/31/2014	HC015 – Home Choice Case Management	1	\$0.00	HC1611 – CareStar, Inc., 800-616-3718
1/14/2014 – <b>(3)</b>	HC003 – Independent Living Skills Training	576 <b>(4)</b>	\$0.00	HC1512 - Jefferson Behavioral Health
1/14/2014 – <b>(3)</b>	HC004 – Community Support Coaching	288 <b>(5)</b>	\$0.00	HC1512 - Jefferson Behavioral Health
1/14/2014 – <b>(3)</b>	HC005 – Social Work/Counseling Services	144 <b>(6)</b>	\$0.00	HC1512 - Jefferson Behavioral Health

**(1) Community Living Administrator**

**(2) Case Management Contact Information (Including phone number)**

**(3) Begin Date authorizing Service Providers**

**(4) Number of units authorized for Independent Living Skills Training (1-Unit = 15 minutes)**

**(5) Number of units authorized for Community Support Coaching (1-Unit = 15 minutes)**

**(6) Number of units authorized for Social Work Counseling (1-Unit = 15 minutes)**

- Services cannot begin prior to the Begin Date.
- Services cannot continue beyond the End Date.
- HCCM responsibility to contact service providers prior to Service Plan submission.  
Providers will receive additional documentation about the individual which may include: the Community Readiness Tool, Eligibility Checklist, and Enrollment Form.
- Providers receive updated service plans whenever they a revision is made by HOME Choice Operations.
- Community Support Coaching is the only service that may be authorized prior to discharge.

## C. Service Claim Request

Providers shall submit this document to Morning Sun Financial Services **within 90 days of the service date.**

<b>Request Date</b>	Click here to enter a date.				
<b>Participant Name</b> (Last, First, MI)	Click here to enter text.			<b>Participant's Medicaid Billing Number</b> (12 Digits)	Click here to enter text.
<b>HOME Choice Provider Name</b> (Agency/Independent)	Click here to enter text.			<b>HOME Choice Provider Number</b>	Click here to enter text.
<b>Contact Person</b>	Click here to enter text.			<b>Phone Number</b>	Click here to enter text.
<b>Email Address</b>	Click here to enter text.		<b>Mailing Address</b>	Click here to enter text.	
<b>City</b>	Click here to enter text.		<b>State</b>	Click here to enter text.	<b>Zip Code</b> Click here to enter text.

Date of Service			Begin Time	End Time	Service Code	Service Type Rendered (See reverse side of this document)	Units Billed	Unit Rate	Total Charges
MM	DD	YYYY							
						Click here to enter text.			
						Click here to enter text.			
						Click here to enter text.			
						Click here to enter text.			
						Click here to enter text.			
						Click here to enter text.			
						Click here to enter text.			
						Click here to enter text.			
						Click here to enter text.			
						Click here to enter text.			
<b>Total:</b>									

**Provider Certification**

*I hereby certify that I have rendered the above HOME Choice services in accordance with the HOME Choice provider agreement. I understand that payment and satisfaction of this claim may be from the Federal and State funds and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.*

**Provider Signature:** Click here to enter text.

**Mail or Fax this document to:**

Morning Sun Fiscal Services  
 9400 Golden Valley Road  
 Golden Valley, MN 55427  
 Fax: (855) 233-5233

**Questions regarding payment of HOME Choice Service**

**Claims should be directed to:**

Phone: (866) 233-7024  
 Email: [MS-Ohexpenses@morningsunfs.com](mailto:MS-Ohexpenses@morningsunfs.com)

## Information Regarding HOME Choice Services

HOME Choice Service Code	Service Name	Max. Units/Hours Allowed
HC001	Nursing – RN	Up to 528 hours
HC002	Nursing – LPN	Up to 528 hours
HC003	Independent Living Skills Training	Up to 144 hours
HC004	Community Support Coach	Up to 72 hours
HC005	Social Work/Counseling Service	Up to 36 hours
HC006	Nutritional Counseling Service	Up to 36 hours
HC007	Communication Aide Service	1 Unit
HC012	In-Home Respite Service	\$2,000 in total Respite Service
HC013	Out-of-Home Respite Service	\$2,000 in total Respite Service
HC014	Camp Respite Service	\$2,000 in total Respite Service

## D. Change in Status Form

Participant Name <i>(Last, First, MI)</i>		Medicaid ID # <i>(12 digits)</i>		
<b>Section 1: PRE-ENROLLMENT TERMINATION</b>				
<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>			
<b>Section 2: INSTITUTIONALIZATION OR TRANSFER FROM ONE FACILITY TO ANOTHER AFTER ENROLLMENT</b>				
<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		
<b>Section 3a: RESIDENCE INFORMATION</b>				
<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>				
<b>Move Type</b>		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 <b>(Complete Section 2.)</b>	<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 <b>(Complete section 3a.)</b>	<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, 5<sup>th</sup> 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

#### CONSUMERS AND TRANSITION TEAM

- The Consumer Page is more dedicated to information that the consumers would need
- The **“Apply for HOME Choice”** button opens a PDF version of the application for an individual to fill out
- The **Transition Team link** opens a new page that describes the team that 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 by providers
- This page can be easily accessed from the provider page
- Current and past training materials can be found here including agendas, presentations and additional 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. Ohio Administrative Code: HOME Choice Provider Rule

### 5160-51-04 Helping Ohioans move, expanding choice (HOME choice) program definitions of covered services and provider qualifications.

(A) This rule sets forth the covered services available to a helping Ohioans move, expanding choice (hereafter referred to as HOME choice) program participant as well as provider requirements for those services.

(B) "Communication aid services" include devices, systems or services necessary to assist a HOME choice participant with hearing, speech or vision impairments to effectively communicate with others.

(1) Communication aid services include, but are not limited to:

- (a) Augmentative communication devices or systems that transmit or produce a message or symbols in a manner that compensates for the participant's communication impairment;
- (b) Computers and computer equipment;
- (c) Other mechanical and electronic devices;
- (d) Cable and internet access;
- (e) The cost of installation, repair, maintenance and support of any covered communication aid;
- (f) Interpreter services that support the HOME choice participant's integration into the community. Interpreter services refers to the process by which the interpreter conveys one person's message to another by incorporating both the message and the attitude of the communicator; and
- (g) New technologies and any other devices that achieve the objective of the service.

(2) If the HOME choice participant is enrolled on a home and community based services (HCBS) waiver, the participant must exhaust similar waiver services that are available before utilizing communication aid services through HOME choice.

(3) A provider of communication aid services must be an agency provider who is:

- (a) An Ohio department of medicaid (ODM)-approved provider of supplemental adaptive and assistive device services in accordance with rule 5160-46-04 or rule 5160-50-04 of the Administrative Code, as appropriate; or
- (b) An Ohio department of developmental disabilities (DODD)-certified provider of adaptive and assistive equipment services in accordance with rule 5123:2-2-01 of the Administrative Code; or
- (c) An Ohio department of aging (ODA)-certified long term care provider of home medical equipment and supplies in accordance with rule 173-39-03 of the Administrative Code.

(4) Reimbursement for communication aid services shall not exceed a total of five thousand dollars during the participant's demonstration period. The same type of communication aid equipment may be approved by ODM for the HOME choice participant when there is a documented need.

(5) In order to submit a claim and be reimbursed for communication aid services, the provider delivering the service must:

- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
- (b) Be identified as the communication aid service provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

(C) "Community support coaching" is a service provided for the purpose of guiding, educating and empowering a HOME choice participant, and the participant's guardian and family members, as applicable, before, during and after the participant's transition from an institution into the community.

- (1) The community support coach shall:
  - (a) Communicate with and educate the participant about vital aspects of the transition process;
  - (b) Assist the HOME choice participant in:
    - (i) Making informed and independent choices,
    - (ii) Setting and achieving short-term and long-term goals,
    - (iii) Managing multiple tasks,
    - (iv) Identifying options and problem solving,
    - (v) Identifying community resources available to the participant, and
    - (vi) Connecting to potential employment opportunities before, during and after transition.
  - (c) Provide the case manager, service and support administrator, or HOME choice case manager, as appropriate, with written status reports during the participant's demonstration period, as prescribed by the HOME choice service plan.
- (2) A provider of community support coaching services shall not be the same staff person, of a transition coordination agency, who provided transition coordination services to the same participant during their pre-transition period.
- (3) Community support coaching shall not duplicate independent living skills training available through HOME choice, similar waiver services available to participants enrolled on an HCBS waiver, or services available through the medicaid state plan.
- (4) A provider of community support coaching must:
  - (a) Be a non-agency provider, or
  - (b) Be an agency provider that is either:
    - (i) A community mental health provider certified by the Ohio department of mental health and addiction services (OhioMHAS) in accordance with Chapters 5122-24 to 5122-29 of the Administrative Code, or
    - (ii) A non-profit agency provider.
- (5) Non-agency providers of community support coaching services, and all staff members of agency providers of community support coaching services with direct participant contact must:
  - (a) Have either:
    - (i) A disability and has lived in an institution and successfully transitioned to the community, and/or
    - (ii) Experience transitioning individuals from an institution to the community.
  - (b) Be age eighteen or older;
  - (c) Possess a valid Ohio driver license and automobile liability insurance when providing transportation;
  - (d) Not be the participant's legally responsible family member; and
  - (e) Not be the participant's case manager or service and support administrator, as those terms are defined in rule 5160-51-01 of the Administrative Code.
- (6) In order to a submit claim and be reimbursed for community support coaching, the provider delivering the service must:
  - (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
  - (b) Be identified as the community support coach provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

(D) "Community transition services" are goods, services and support for the purpose of addressing an identified need in a participant's HOME choice service plan, including improving and maintaining the participant's opportunities for inclusion in the community.

(1) Community transition services are intended to:

- (a) Decrease the need for formal support services and other medicaid services;
- (b) Take into consideration the appropriateness and availability of a lower cost alternative for comparable services that meet the participant's needs;
- (c) Promote community inclusion and family involvement;
- (d) Improve the participant's health and welfare in the home and community;
- (e) Be provided when the participant does not have the funds to purchase the services, or the services are not available through another source;
- (f) Assist the participant in developing and maintaining personal, social, physical or work-related skills; and
- (g) Assist the participant in living independently in the home and community.

(2) Community transition services include:

- (a) Transportation expenses up to a maximum of five hundred dollars during the participant's pre-transition period and for thirty days after transitioning to the community;
- (b) Initial transition expenses up to a maximum of two thousand dollars including, but not limited to the following:
  - (i) Security deposit and rent required to lease a qualified residence;
  - (ii) Essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens;
  - (iii) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
  - (iv) Services necessary for the participant's health and welfare, such as pest control and one-time cleaning prior to moving in to the residence;
  - (v) Moving expenses;
  - (vi) Necessary home accessibility adaptations; and
  - (vii) Initial grocery purchase, i.e., food and household supplies.

(3) Community transition services do not include:

- (a) Experimental or prohibited treatments;
- (b) The ongoing cost of rent;
- (c) Ongoing utility charges;
- (d) Ongoing grocery expenses;
- (e) Cigarettes and alcohol;
- (f) Electronics and other household appliances or items that are intended to be used for entertainment or recreational purposes; and
- (g) Cable and/or internet access.

(4) Community transition services shall not duplicate similar services available to a participant who is enrolled on an HCBS waiver except when the participant is enrolled on an ODA-administered waiver or ODM-administered waiver. Participants enrolled on an ODA-administered waiver or ODM-administered waiver shall use HOME choice community transition services in lieu of, but not in addition to, the community transition services available through the waiver.

(5) Reimbursement for community transition services shall not exceed a cumulative maximum of two thousand five hundred dollars for the items set forth in paragraph (D)(2) of this rule.

(6) In order to submit a claim and be reimbursed for community transition services:

- (a) The specific goods and services purchased shall have been based upon the participant's needs; and
- (b) The goods and/or services must have been identified on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date for which the provider is authorized to furnish community transition services to the participant. The provider will not be reimbursed for unauthorized community transition services including community transition services provided in excess of what is documented on the participant's service plan for that provider.

(7) During the HOME choice participant's demonstration period, the purchase of community transition services shall be coordinated by the participant's case manager, service and support administrator and/or HOME choice case manager as appropriate and as approved by ODM prior to submission for reimbursement to the ODM-designated HOME choice financial management service (FMS) provider.

(E) "HOME choice nursing services" are intermittent services provided to a HOME choice participant that require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. All nurses providing HOME choice nursing services shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and rules of the Administrative Code adopted thereunder, and shall possess a current, valid and unrestricted license with the Ohio board of nursing.

(1) HOME choice nursing services do not include:

- (a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules of the Administrative Code adopted thereunder and to be performed by providers who are not licensed nurses;
- (b) Services that require the skills of a psychiatric nurse;
- (c) Visits performed for the purpose of conducting an RN assessment, including but not limited to an outcome and assessment information set (OASIS) assessment or any other assessment;
- (d) Visits or communication performed by an RN either for the purpose of RN consultation or for the purpose of meeting supervisory requirements;
- (e) Visits performed for the purpose of meeting the home care attendant service RN visit requirements set forth in rules 5160-46-04.1 and 5160-50- 04.1 of the Administrative Code.

(2) HOME choice nursing services shall not duplicate similar waiver services available to participants enrolled on an HCBS waiver or available through medicaid state plan home health nursing or private duty nursing services.

(3) HOME choice nursing services may be provided on the same day as, but not concurrently with an RN assessment or an RN consultation.

(4) A provider of HOME choice nursing services must be a medicaid provider who is either:

- (a) Employed by a medicare-certified, or otherwise-accredited home health agency; or
- (b) An approved ODM-administered waiver non-agency nursing service provider in accordance with rule 5160-46-04 or 5160-50-04 of the Administrative Code.

(5) A provider of HOME Choice nursing services must not be:

- (a) The participant's legally responsible family member unless the family member is employed by a medicare-certified, or otherwise-accredited home health agency; or
- (b) The foster caregiver of the participant.

(6) Non-agency LPNs, at the direction of an RN, must:

- (a) Meet with the directing RN at least every sixty days after the initial visit to evaluate the provision of HOME choice nursing services and the LPN's performance of those services, and to ensure that services are being provided in accordance with the approved plan of care and within the LPN's scope of practice; and
- (b) Conduct an in-person visit with the participant and the directing RN before initiating services and at least once every one hundred twenty days for the purpose of evaluating the provision of HOME choice nursing services, the participant's satisfaction with care delivery and the LPN's performance, and to ensure

that services are being provided in accordance with the approved plan of care and within the LPN's scope of practice

(7) All HOME choice nursing service providers must maintain a clinical record for each participant served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency HOME choice nursing service providers must maintain the clinical records at their place of business, and maintain a copy in the participant's residence. For the purposes of this rule, the place of business must be a location other than the participant's residence. At a minimum, the clinical record must include:

- (a) Participant identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers;
- (b) The participant's medical history;
- (c) Name of the participant's treating physician;
- (d) A copy of the HOME choice service plan approved by ODM;
- (e) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope and duration of the nursing services being performed. When services are performed by an LPN at the direction of an RN, the clinical record shall include documentation that the RN has reviewed the plan of care with the LPN. The plan of care must be recertified by the treating physician every sixty days, or more frequently if there is a significant change in the participant's condition;
- (f) Documentation of verbal orders given by the treating physician to the nurse. The nurse must document, in writing, the physician's verbal orders, the date and time the orders were given, and sign the entry in the clinical record. The nurse must subsequently secure documentation of the verbal orders, signed and dated by the treating physician;
- (g) Clinical notes, signed and dated by the non-agency LPN, in all instances when a non-agency LPN is providing HOME choice nursing services. The LPN must maintain documentation of all consultations between the LPN and the directing RN, and the in-person visits between the LPN, the participant and the directing RN;
- (h) Documentation of all drug and food interactions, allergies and dietary restrictions;
- (i) A copy of any existing advanced directives including, but not limited to, do not resuscitate orders or medical powers of attorney;
- (j) Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and the participant or their guardian verifying the service delivery upon completion of service delivery. The participant or their guardian's signature of choice shall be documented on the HOME choice service plan, and shall include, but not be limited to any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature;
- (k) Clinical notes, signed and dated by the nurse, documenting all communications between the treating physician and other members of the multidisciplinary team; and
- (l) A discharge summary, signed and dated by the nurse at the conclusion of the participant's demonstration period, or at the point the nurse is no longer going to provide services to the participant, or when the participant no longer needs HOME choice nursing services. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-up or referrals.

(8) In order to submit a claim and be reimbursed for HOME choice nursing services, the provider delivering the service must:

- (a) Meet the conditions of participation and enrollment criteria set forth in rule [5160-51-03](#) of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
- (b) Be identified as the HOME choice nursing services provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will

not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider;

(c) Be identified as the provider on, and be performing HOME choice nursing services pursuant to the participant's plan of care, as that term is defined in rule 5160-51-01 of the Administrative Code. The plan of care must be signed and dated by the participant's treating physician; and

(d) Have provided the services for one participant during an in-person visit, or for two or three participants in a group setting during an in-person visit.

(F) "Independent living skills training" is information, educational supports and resources provided to a HOME choice participant for the purpose of developing skills, knowledge or abilities needed to live more independently.

(1) Independent living skills training focuses on:

(a) Community living skills including, but not limited to:

- (i) Identifying and accessing existing community resources,
- (ii) Job training and seeking employment opportunities,
- (iii) Linking to legal resources,
- (iv) Negotiating transportation systems and arranging transportation,
- (v) Safety in the community, and
- (vi) Travel training.

(b) Financial management skills including, but not limited to:

- (i) Budgeting,
- (ii) Finding a bank and establishing an account,
- (iii) Managing entitlements and insurance,
- (iv) Paying bills and taxes,
- (v) Understanding credit,
- (vi) Understanding contracts,
- (vii) Using a bank machine,

(c) Health management skills including, but not limited to:

- (i) Assessing the need for, and accessing, adaptive and assistive devices,
- (ii) Crisis care/recovery services,
- (iii) Efficiently managing nutrition and diet,
- (iv) Ensuring emergency preparedness,
- (v) Linking to medical/dental services,
- (vi) Managing and accessing medical supplies,
- (vii) Managing medication,
- (viii) Talking to the doctor, and
- (ix) Training service providers;

(d) Home management skills including, but not limited to:

- (i) Grocery shopping, cooking and meal planning,
- (ii) Housekeeping and laundry,
- (iii) Operating simple technology,
- (iv) Personal shopping,
- (v) Requesting and/or completing simple repairs, and

- (vi) Safety at home;
  - (e) Personal skills including, but not limited to:
    - (i) Daily functions such as hygiene, dressing and undressing,
    - (ii) Scheduling, and
    - (iii) Utilization of leisure/education/physical/emotional activities; and
  - (f) Social skills development including, but not limited to:
    - (i) Building communication skills,
    - (ii) Knowing when and how to ask for help,
    - (iii) Learning how to be a good neighbor/roommate, and
    - (iv) Learning how to work with providers.
- (2) Independent living skills training shall not duplicate community support coaching services available through HOME choice, similar waiver services available to participants enrolled on an HCBS waiver, or services available through the medicaid state plan.
- (3) If the HOME choice participant is enrolled on a DODD-administered waiver, the participant must access homemaker/personal care in lieu of independent living skills training.
- (4) The independent living skills training provider shall provide the case manager, service and support administrator, or HOME choice case manager, as appropriate, with written status reports as directed during the participant's demonstration period.
- (5) A provider of independent living skills training must be either:
- (a) A community mental health provider certified by OhioMHAS in accordance with Chapters 5122-24 to 5122-29 of the Administrative Code; or
  - (b) A non-profit agency provider whose staff with direct participant contact:
    - (i) Have either:
      - (a) A disability and has lived in an institution and successfully transitioned to the community and/or;
      - (b) Experience transitioning individuals from an institution to the community, and
    - (ii) Must have knowledge and experience about:
      - (a) Local community resources,
      - (b) Applicable disability laws and regulations, and
    - (iii) Are age eighteen or older; and
    - (iv) Possess a valid Ohio driver license and automobile liability insurance when providing transportation.
- (6) In order to submit a claim and be reimbursed for independent living skills training, the provider delivering the service must:
- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule;
  - (b) Be identified as the independent living skills training provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider; and
  - (c) Have provided the service to one participant, or to two or three participants in a group setting, or four or more participants in a classroom setting, during the same in-person visit.

(G) "Nutritional consultation services" are services that provide individualized guidance to a HOME choice participant who has special dietary needs. Nutritional consultation takes into consideration the participant's health, cultural, religious, ethnic and socio-economic background and dietary preferences and/or restrictions.

(1) Nutritional consultation services shall not duplicate similar waiver services available to participants enrolled on an HCBS waiver or services available through the medicaid state plan.

(2) A provider of nutritional consultation services must be:

(a) A medicaid provider of nutritional consultation services as certified by DODD in accordance with rule 5123:2-2-01 of the Administrative Code, or an ODA-certified long term care provider of nutritional consultation services in accordance with rule 173-39- 02.10 of the Administrative Code; and,

(b) Be a dietitian who:

- (i) Is registered by the commission on dietetic registration; and
- (ii) Maintains a license in good standing with the Ohio board of dietetics;

(3) All providers of nutritional consultation services must:

(a) Conduct an initial individual assessment of the participant's nutritional needs, and subsequent assessments when necessary, using an assessment tool that identifies whether the participant is at nutritional risk or identifies a nutritional diagnosis that the dietitian will treat. The assessment must include:

- (i) A history of the participant's height and weight;
- (ii) An assessment of the participant's nutrient intake adequacy;
- (iii) A review of the participant's medications, medical diagnoses and diagnostic test results;
- (iv) An assessment of the participant's verbal, physical and motor skills that could be attributable to, or affect, nutrient needs;
- (v) An assessment of caregiver and participant interactions during feeding; and
- (vi) An assessment of the need for additional adaptive equipment and/or other community resources and/or services for the participant.

(b) Develop, implement, evaluate and revise, as necessary, a nutrition intervention plan with the assistance of the participant and/or their guardian, case manager and when applicable, the treating physician and other relevant service providers. The plan shall be used to prioritize and address the identified nutrition problems. It must include purposely planned actions designed to change nutrition-related behavior, risk factors, environmental conditions or health status, and at a minimum, it must address the following:

- (i) Appropriate dietary restrictions and modifications;
- (ii) Specific nutrients that may be required or limited;
- (iii) Feeding modality;
- (iv) Nutrition education and counseling; and
- (v) Expected measurable indicators and outcomes related to the participant's nutrition goals.

(c) Provide services pursuant to a plan of care for nutritional consultation services that is signed and dated by the treating physician. The plan of care for nutritional consultation services must be re certified by the treating physician every sixty days, or more frequently if there is a significant change in the participant's condition.

(d) Furnish the case manager, service support administrator, or HOME choice case manager, as appropriate, as well as the participant and/or the participant's guardian with a copy of the assessment and the nutrition intervention plan no later than seven working days after completion of the assessment.

(e) Furnish evidence, upon request, that the nutrition intervention plan was developed and services were delivered in accordance with professional licensure requirements.

(f) Maintain a clinical record for each participant served. At a minimum, the clinical record must include:

- (i) Participant identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers;
- (ii) The participant's medical history;
- (iii) Name of the participant's treating physician;
- (iv) Treating physician's authorization for a nutritional assessment;
- (v) A copy of the HOME choice service plan approved by ODM;
- (vi) A copy of the initial and all subsequent individual assessments of the participant's nutritional needs;
- (vii) A copy of the initial and all subsequent plans of care for nutritional consultation services specifying the type, frequency, scope and duration of the services being performed;
- (viii) A copy of the initial and all subsequent nutrition intervention plans developed and implemented;
- (ix) Documentation of all drug and food interactions, allergies and dietary restrictions;
- (x) Documentation that clearly shows the date of nutritional consultation service delivery, including copies of all nutritional assessments conducted and all nutrition intervention plans developed and implemented; and
- (xi) A discharge summary, signed and dated by the nutritional consultation provider at the conclusion of the participant's demonstration period, or at the point the dietitian is no longer going to provide services to the participant, or when the participant no longer needs nutritional consultation services. The summary shall include progress made to date toward goal achievement and nutritional outcomes, and any recommended follow-ups and/or referrals.

(4) In order to submit a claim and be reimbursed for nutritional consultation services, the provider delivering the service must:

- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
- (b) Be identified as the nutritional consultation services provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

(H) "Respite services" are services provided on a short-term basis to a HOME choice participant who is not enrolled on an HCBS waiver, and who is unable to care for himself or herself, due to the temporary absence of or periodic relief for the primary caregiver. Respite services include all of the necessary care that the primary caregiver would normally provide during that period. Respite services may be provided in-home, out-of-home or in a day camp setting in accordance with the participant's HOME choice service plan.

(1) In-home respite services are services provided in the participant's place of residence and shall include, but not be limited to:

- (a) General supervision of the participant;
- (b) Homemaker services to assist with housekeeping chores, meal preparation and shopping;
- (c) Personal care services to assist with bathing, dressing and exercise;
- (d) Skilled nursing services to assist with medical needs;
- (e) Accompanying the participant to community outings; and
- (f) Other related services.

(2) Out-of-home respite services are services provided in an out-of-home setting that meets the requirements set forth in paragraph (H)(4)(b) of this rule, and that require an overnight stay. Out-of-home respite services shall include, but not be limited to:

- (a) Personal care services;
  - (b) Skilled nursing services; and
  - (c) Three meals per day that meet the participant's dietary needs.
- (3) Day camp respite services are provided by a day camp that is licensed or certified by a recognized, accredited entity. Day camp respite services shall:
- (a) Be provided for the purpose of therapeutic intervention that will meet the emotional and behavioral needs of the HOME choice participant;
  - (b) Include, but not be limited to:
    - (i) Personal care services;
    - (ii) Skilled nursing services; and
    - (iii) Meal services commensurate with the camp respite setting that meet the participant's dietary needs; and
  - (c) Not be provided in the HOME choice participant's place of residence.
- (4) A provider of respite services must be one of the following:
- (a) An in-home respite provider who is:
    - (i) A homemaker/personal care provider certified by DODD in accordance with rules 5123:2-9-30 and 5123:2-2-01 or rule 5123:2-3-19 of the Administrative Code, as applicable; or
    - (ii) An approved ODM-administered waiver personal care aide service provider or nursing service provider in accordance with rule 5160-46-04 or 5160-50-04 of the Administrative Code; or
  - (b) An out-of-home respite provider that is:
    - (i) Approved by ODM in accordance with rule 5160-45-04 of the Administrative Code; or
    - (ii) An intermediate care facility for individuals with intellectual disabilities (ICF-IID) that meets the requirements set forth in rules 5160-3-02 and 5160-3-02.3 of the Administrative Code; or
    - (iii) A non-ICF-IID entity (i.e., a group home) licensed by DODD in accordance with rule 5123:2-3-02 of the Administrative Code; or
    - (iv) A nursing facility that meets the requirements set forth in rules 5160-3-02 and 5160-3-02.3 of the Administrative Code; or
    - (v) Another licensed setting approved by ODM or its designee, including but not limited to, a hospice or hospital; or
  - (c) A camp respite provider that is licensed or certified by a recognized, accredited entity that includes, but is not limited to, the American camping association.
- (5) All providers of in-home respite services must:
- (a) Maintain evidence of the completion of twelve hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. Agency providers must maintain evidence of non-licensed direct care staff's completion of the same requirements. In order to maintain ongoing provider status, in-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter;
  - (b) Not be the participant's legally responsible family member;
  - (c) Ensure that any skilled nursing services provided are within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code; and
  - (d) Provide care as specified by task-based instruction for the provision of personal care services. Agency providers must provide such task-based instruction to direct care staff providing personal care services. Non-agency providers will receive instruction regarding their necessary care from the participant and/or their guardian and as documented in their plan of care.

(6) All providers of out-of-home respite services must:

- (a) Provide insurance coverage of a participant's loss due to theft, property damage or personal injury, and maintain a written procedure identifying the steps a participant takes to file a liability claim. Documentation verifying the coverage shall be provided to ODM upon request;
- (b) Maintain evidence of non-licensed direct care staff's completion of twelve hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In order to maintain ongoing provider status, in-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter;
- (c) Ensure that any skilled nursing services provided are within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code; and
- (d) Provide task-based instruction to direct care staff providing personal care services.

(7) All respite service providers must maintain a record for each participant served in a manner that protects the confidentiality of the records. Providers of in-home respite must ensure at a minimum the record contains the information set forth in paragraphs (H)(7)(a) to (H)(7)(g) of this rule. At a minimum, providers of out-of-home respite must ensure the record contains the information set forth in paragraphs (H)(7)(a) to (H)(7)(h) of this rule.

- (a) Participant identifying information including, but not limited to, name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification number;
- (b) The participant's medical history;
- (c) A copy of the initial and all subsequent HOME choice service plans;
- (d) A copy of any existing advance directives including, but not limited to, do not resuscitate orders or medical powers of attorney;
- (e) Documentation of all drug and food interactions, allergies and dietary restrictions;
- (f) Documentation including, but not limited to, case notes clearly showing the date and outcome of respite service delivery, including tasks performed or not performed;
- (g) Documentation required for providers of ODM administered waiver nursing services as set forth in rule 5160-46-04 or 5160-50-04 of the Administrative Code when skilled nursing services are provided during respite services;
- (h) A discharge summary, signed and dated by the respite service provider, at the point the provider is no longer going to furnish respite services to the participant, or when the participant no longer needs respite services. The summary should indicate any recommended follow-ups or referrals.

(8) In order to submit a claim and be reimbursed for respite services the provider must:

- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
- (b) Be identified as the respite services provider on the participant's HOME choice service plan as approved by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

(I) "Service animals" are animals that are trained to perform tasks for HOME choice participants that the participants are unable to perform for themselves.

(1) Tasks performed by service animals include, but are not limited to:

- (a) Guiding people who are blind;
- (b) Alerting people who are deaf;
- (c) Pulling wheelchairs;
- (d) Alerting and protecting participants who are having a seizure;

(e) Carrying and picking up things for participants with mobility impairments; and

(f) Assisting participants with mobility impairments with balance.

(2) Service animals may include, but are not limited to:

(a) Seeing eye dogs;

(b) Hearing dogs; and

(c) Service monkeys.

(3) Expenses related to the use of service animals include, but are not limited to:

(a) First-year costs associated with the raising of the animal;

(b) Housing, feeding, upkeep and medical care of the animal during training;

(c) Actual training of the animal, participant orientation and related transportation, room/board and administrative activities;

(d) Equipment and supplies;

(e) Animal health insurance; and

(f) Transportation to the veterinarian.

(4) If the HOME choice participant is enrolled on a DODD-administered waiver, the participant must exhaust similar waiver services that are available before utilizing the service animal service through HOME choice.

(5) A provider of service animal services must be an agency provider of adaptive and assistive equipment services as certified by DODD in accordance with rule 5123:2-2-01 of the Administrative Code.

(6) Reimbursement for service animal expenses shall not exceed a total of eight thousand dollars during the participant's demonstration period.

(7) In order to submit a claim and be reimbursed for service animal services, the provider delivering the service must:

(a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and

(b) Be identified as the service animal service provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

(J) "Social work/counseling services" are transitional services provided to a HOME choice participant, their guardian, caregiver and/or family member on a short-term basis to promote the participant's physical, social and emotional well-being. Social work/counseling services promote the development and maintenance of a stable and supportive environment for the participant.

(1) Social work/counseling services can include, but are not limited to, crisis interventions, grief counseling and/or other social service interventions that support the participant's health and welfare.

(2) Social work/counseling services shall not:

(a) Take the place of case management services; or

(b) Duplicate similar waiver services available to participants enrolled on an HCBS waiver or through the medicaid state plan.

(3) A provider of social work/counseling services must be either:

(a) A non-agency provider who shall maintain documentation of licensure by the applicable Ohio licensure board and have at least one year of social work/counseling experience, and is:

(i) A licensed professional clinical counselor (LPCC), licensed independent social worker (LISW), or independent marriage and family therapist (IMFT) who holds a current, valid and unrestricted

license to practice issued by the counselor, social worker, and marriage and family therapist board in accordance with Chapter 4757. of the Revised Code; or

(ii) A psychologist who holds a current, valid and unrestricted license to practice issued by the state board of psychology of Ohio in accordance with Chapter 4732. of the Revised Code; or

(iii) An RN who holds a current, valid and unrestricted license to practice issued by the Ohio board of nursing in accordance with Chapter 4723. of the Revised Code and holds a masters degree in nursing (MSN) with a specialization or concentration in psychiatric or mental health nursing; or

(b) An agency provider who shall maintain documentation that all direct care social work/counseling staff are licensed by the applicable Ohio licensure board, and have at least one year of social work/counseling experience, and:

(i) Is a medicaid provider of social work counseling services as certified by DODD in accordance with rule 5123:2-2-01 of the Administrative Code, or as certified by OhioMHAS in accordance with Chapters 5122-24 to 5122-29 of the Administrative Code, or is an ODA-certified long term care provider of social work counseling services in accordance with rule 173-39- 02.12 of the Administrative Code; and

(ii) Ensures that staff providing direct care is one of the following:

(a) An LPCC, licensed professional counselor (LPC), LISW, licensed social worker (LSW), marriage and family therapist (MFT), or IMFT who holds a current, valid and unrestricted license to practice issued by the counselor, social worker, and marriage and family therapist board in accordance with Chapter 4757. of the Revised Code;

(b) A psychologist who holds a current, valid and unrestricted license to practice issued by the state board of psychology of Ohio in accordance with Chapter 4732. of the Revised Code; or

(c) An individual who holds a current, valid and unrestricted license as an RN from the Ohio board of nursing accordance to Chapter 4723. of the Revised Code, and holds an MSN with a specialization or concentration in psychiatric or mental health nursing; and

(iii) Ensures that LSWs, LPCs and MFTs are supervised in accordance with Chapter 4757. of the Revised Code, and that the supervisor of an LSW, LPC or MFT co-signs all initial assessments and social work/counseling intervention plans prepared by the LSW, LPC, MFT or MSN.

(4) A provider of social work/counseling services must:

(a) Conduct individual assessments in order to evaluate the HOME choice participant's psycho-social, financial and environmental status;

(b) Develop and revise, as necessary, with the assistance of the participant, and/or the participant's guardian, caregiver(s) and the case manager or service and support administrator, as appropriate, a treatment plan that includes the recommended method of treatment and the recommended number of counseling sessions;

(c) Ensure that the treatment plan is implemented; and

(d) Furnish to the case manager, service and support administrator, or HOME choice case manager, a copy of the individual assessment report and the treatment plan no later than seven working days after completion of the individual assessment. The participant and/or the participant's guardian shall also be furnished with a copy of the individual assessment report and the treatment plan unless otherwise specified by the treatment plan.

(e) Maintain a clinical record for each participant served. At a minimum, the clinical record must include:

(i) Participant identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification information;

(ii) The participant's medical history;

(iii) Name of the participant's treating physician;

- (iv) A copy of the HOME choice service plan approved by ODM;
- (v) A copy of the initial and all subsequent individual assessments;
- (vi) A copy of the initial and all revised treatment plans;
- (vii) A copy of any existing advanced directives including, but not limited to, do not resuscitate orders or medical powers of attorney;
- (viii) Documentation of all drug and food interactions, allergies and dietary restrictions;
- (ix) Documentation that clearly shows the date of social work/counseling service delivery;
- (x) A discharge summary, signed and dated by the social work/counseling service provider at the conclusion of the participant's demonstration period, or at the point the provider is no longer going to provide services to the participant, or when the participant no longer needs social work/counseling services. The summary should include documentation regarding service outcomes and progress made toward goal achievement and indicate any recommended follow-ups and/or referrals.

(5) In order to submit a claim and be reimbursed for social work/counseling services, the provider delivering the service must:

- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
- (b) Be identified as the social work/counseling services provider on the participant's HOME choice service plan as approved by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

Replaces: 5160-51-04, 5160-51-05

Effective: 2/1/2015

Five Year Review (FYR) Dates: 02/01/2020

Promulgated Under: 119.03

Statutory Authority: 119.03, 5164.02

Rule Amplifies: 5162.03, 5164.02, 5166.02, 5164.90

Prior Effective Dates: 7/1/08, 6/1/09, 9/9/10, 8/1/11

# H. Provider Agreement

## OHIO HOME CHOICE DEMONSTRATION PROGRAM PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT

**Submit completed signed application/agreement with required attachments to**

HOME Choice Operations Unit  
P.O. Box 182709, 5<sup>th</sup> Floor  
Columbus, Ohio 43218-2709

**Provider Types** (Check ALL that apply)

Agency Providers	Non-Agency Providers
<input type="checkbox"/> HOME Choice Agency Nursing <input type="checkbox"/> HOME Choice Agency Independent Living Skills Training <input type="checkbox"/> HOME Choice Agency Community Support Coach <input type="checkbox"/> HOME Choice Agency Social Work/Counseling Services <input type="checkbox"/> HOME Choice Agency Nutritional Consultation Services <input type="checkbox"/> HOME Choice Agency Communication Aids <input type="checkbox"/> HOME Choice Agency Service Animals <input type="checkbox"/> HOME Choice In-Home Respite Services <input type="checkbox"/> HOME Choice Out-of-Home Respite Services <input type="checkbox"/> HOME Choice Camp Respite Services	<input type="checkbox"/> HOME Choice Non-Agency RN Nursing <input type="checkbox"/> HOME Choice Non-Agency LPN Nursing <input type="checkbox"/> HOME Choice Non-Agency Community Support Coach <input type="checkbox"/> HOME Choice Non-Agency Social Work/Counseling Services <input type="checkbox"/> HOME Choice Non-Agency Nutritional Consultation Services <input type="checkbox"/> HOME Choice In-Home Respite Services

**Provider Identification** (Please print or type entries)

<b>Individual Name</b> (First, Middle Initial, and Last) or <b>Agency Name</b>			
Social Security or EIN Number *	Current or previous Medicaid Number(s) (if applicable)		
Current NPI Number**	License Number ***	License Expiration Date (mm/dd/yyyy)	

\*You must attach a completed and signed W-9 form. Do not use GROUP tax ID number.  
 \*\*You must attach a copy of the notice from the NPI Enumerator to verify the NPI Number.  
 \*\*\*You must attach a copy of your current state board license.

**Service Location of Practice/Business** (Please print or type entries)

*Non-agency providers may use their home address*

Name/ Building Name/ or Department/ or In care of			
Physical Address (Number, Street, Avenue or Route) (P.O. and Drop Boxes are not acceptable)			Suite Number
City	County	State	Zip Code (Zip +4, if known)
Telephone Number	Cell Phone Number	Email Address	

**"Pay to" Address** (Name & Address to which payment is to be mailed)

*Leave blank if address is the same as "Service Location of Practice/Business"*

Name			
Address			Suite Number
City	State		Zip Code (Zip +4, if known)

**Mailing/Correspondence Address** (Name & Address to which all other material is to be mailed)

*Leave blank if address is the same as "Service Location of Practice/Business"*

Name			
Address			Suite Number
City	County	State	Zip Code (Zip +4, if known)



The HOME Choice Provider may provide the service(s) selected on page one in multiple counties. Please select all the counties in which you agree to provide the selected service(s). For each county selected, you agree to serve all geographic areas therein.

- |                                     |                                    |                                     |                                     |
|-------------------------------------|------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> ADAMS      | <input type="checkbox"/> FAIRFIELD | <input type="checkbox"/> LICKING    | <input type="checkbox"/> PORTAGE    |
| <input type="checkbox"/> ALLEN      | <input type="checkbox"/> FAYETTE   | <input type="checkbox"/> LOGAN      | <input type="checkbox"/> PREBLE     |
| <input type="checkbox"/> ASHLAND    | <input type="checkbox"/> FRANKLIN  | <input type="checkbox"/> LORAIN     | <input type="checkbox"/> PUTNAM     |
| <input type="checkbox"/> ASHTABULA  | <input type="checkbox"/> FULTON    | <input type="checkbox"/> LUCAS      | <input type="checkbox"/> RICHLAND   |
| <input type="checkbox"/> ATHENS     | <input type="checkbox"/> GALLIA    | <input type="checkbox"/> MADISON    | <input type="checkbox"/> ROSS       |
| <input type="checkbox"/> AUGLAIZE   | <input type="checkbox"/> GEAUGA    | <input type="checkbox"/> MAHONING   | <input type="checkbox"/> SANDUSKY   |
| <input type="checkbox"/> BELMONT    | <input type="checkbox"/> GREENE    | <input type="checkbox"/> MARION     | <input type="checkbox"/> SCIOTO     |
| <input type="checkbox"/> BROWN      | <input type="checkbox"/> GUERNSEY  | <input type="checkbox"/> MEDINA     | <input type="checkbox"/> SENECA     |
| <input type="checkbox"/> BUTLER     | <input type="checkbox"/> HAMILTON  | <input type="checkbox"/> MEIGS      | <input type="checkbox"/> SHELBY     |
| <input type="checkbox"/> CARROLL    | <input type="checkbox"/> HANCOCK   | <input type="checkbox"/> MERCER     | <input type="checkbox"/> STARK      |
| <input type="checkbox"/> CHAMPAIGN  | <input type="checkbox"/> HARDIN    | <input type="checkbox"/> MIAMI      | <input type="checkbox"/> SUMMIT     |
| <input type="checkbox"/> CLARK      | <input type="checkbox"/> HARRISON  | <input type="checkbox"/> MONROE     | <input type="checkbox"/> TRUMBULL   |
| <input type="checkbox"/> CLERMONT   | <input type="checkbox"/> HENRY     | <input type="checkbox"/> MONTGOMERY | <input type="checkbox"/> TUSCARAWAS |
| <input type="checkbox"/> CLINTON    | <input type="checkbox"/> HIGHLAND  | <input type="checkbox"/> MORGAN     | <input type="checkbox"/> UNION      |
| <input type="checkbox"/> COLUMBIANA | <input type="checkbox"/> HOCKING   | <input type="checkbox"/> MORROW     | <input type="checkbox"/> VAN WERT   |
| <input type="checkbox"/> COSHOCTON  | <input type="checkbox"/> HOLMES    | <input type="checkbox"/> MUSKINGUM  | <input type="checkbox"/> VINTON     |
| <input type="checkbox"/> CRAWFORD   | <input type="checkbox"/> HURON     | <input type="checkbox"/> NOBLE      | <input type="checkbox"/> WARREN     |
| <input type="checkbox"/> CUYAHOGA   | <input type="checkbox"/> JACKSON   | <input type="checkbox"/> OTTAWA     | <input type="checkbox"/> WASHINGTON |
| <input type="checkbox"/> DARKE      | <input type="checkbox"/> JEFFERSON | <input type="checkbox"/> PAULDING   | <input type="checkbox"/> WAYNE      |
| <input type="checkbox"/> DEFIANCE   | <input type="checkbox"/> KNOX      | <input type="checkbox"/> PERRY      | <input type="checkbox"/> WILLIAMS   |
| <input type="checkbox"/> DELAWARE   | <input type="checkbox"/> LAKE      | <input type="checkbox"/> PICKAWAY   | <input type="checkbox"/> WOOD       |
| <input type="checkbox"/> ERIE       | <input type="checkbox"/> LAWRENCE  | <input type="checkbox"/> PIKE       | <input type="checkbox"/> WYANDOT    |

- A) This provider agreement (Agreement) is a contract between the Ohio Department of Medicaid (ODM) and the undersigned provider of HOME Choice services (the Provider) in which the Provider agrees to provide covered services associated with the provider type(s) identified on page one under the HOME Choice Demonstration Program. By signing this Agreement, the Provider agrees to comply with the terms of this Agreement, federal and state laws, federal and state program requirements, and other requirements as required by ODM. The Provider also specifically agrees to:
- 1) Meet all HOME Choice provider requirements set forth in Chapter 5160-51 of the Ohio Administrative Code.
  - 2) Render HOME Choice services in accordance with Chapter 5160-51 of the Administrative Code and as authorized in the HOME Choice participant's HOME Choice service plan, and only in the amount required by the participants, without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap.
  - 3) Submit claims only for services actually performed and bill in accordance with rule 5160-51-06.
  - 4) Make contact with the HOME Choice participant in order to initiate service provision within 5 business days of receiving authorization from ODM's HOME Choice Operations Unit.
  - 5) Render the services covered under this Agreement, and to not sub-contract any services under this Agreement without the prior, written consent of ODM.
  - 6) Follow all ODM-approved reimbursement policies and procedures established for the HOME Choice financial management services (FMS) provider for all HOME Choice Services, including submission of claims within 90 days of service.
  - 7) Accept the allowable payment for the contracted service as payment-in-full and not seek additional reimbursement for the services from ODM, the participant, guardian, any member of the family, or any other person or entity.
  - 8) Maintain all 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 receipt of payment based upon those records or until any initiated audit is completed, whichever is longer. At a minimum, each participant's record must contain:
    - a) Copies of the HOME Choice participant's service plans showing provider authorization; and
    - b) Copies of provider notes including; dates of services, time of services (begin and end times), validation of service delivery which must include the dated signature of both the provider and the HOME Choice participant, and any other documents related to the services delivered.
  - 9) Act in a prompt and professional manner at all times under this Agreement.
  - 10) Furnish to ODM, the Secretary of the U.S. 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 8 (above) for purposes of an audit or any other purpose within 30 days of the request for such information.
  - 11) Inform ODM within thirty days of any changes to the information provided in the HOME Choice Demonstration Program Provider Enrollment Application/Time Limited Agreement (ODM 02216) (*e.g.*, change in ownership and/or control; change in address or phone number, etc.).
  - 12) Have accurately disclosed in the application section on page two of this document the 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 Title XVIII, Title XIX, or Title XX Services.

- 13) Comply with the criminal record check requirements set forth in Chapter 5160-51 of the Administrative Code.
  - 14) 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
    - c) Possess experience advocating on behalf of participants with disabilities.
    - d) Are eighteen years of age or older.
    - e) Meet the qualifications outlined in the 5160-51-04 for the specific provider type.
  - 15) Have accurately disclosed in the application section of this document whether the Provider has been sanctioned, or is currently subject to sanction under the Medicare or Medicaid programs, or otherwise is prohibited from providing services to Medicare or Medicaid beneficiaries.
  - 16) Comply with the policies and procedures governing HOME Choice including the conditions for participation as set forth in Chapter 5160-51 of the Ohio Administrative Code.
  - 17) Comply with incident reporting requirements in accordance with 5160-51-03, and follow the Protection from Harm guidelines provided by ODM's HOME Choice Operations Unit. Any incidents that are discovered during a contact/visit should be reported by the Provider to the HOME Choice case manager or to the waiver case manager within twenty-four hours of discovery.
- B) ODM reserves the right to place the Provider on probationary status if it has any concerns about its performance under this Agreement. The purpose of placing the Provider on probationary status is to encourage and ensure compliance with this Agreement, as well as to ensure the health and welfare of HOME Choice participants. Examples of situations that may lead to being placed on probationary status include, but are not limited to: failing to comply with this Agreement; failing to act promptly and professionally; being the subject of participant complaints; failing to act in a participant's best interest. While on probationary status, the Provider shall continue providing HOME Choice services under this Agreement to participants for whom the Provider has previously accepted; however, the Provider will not receive additional referrals. The Provider will be removed from probationary status and be eligible to receive new referrals upon satisfactorily demonstrating to ODM that the issue which led to the probationary status has been addressed.
- C) The HOME Choice Demonstration Program is not a Medicaid program. This Agreement does not permit the Provider to furnish medical assistance services through the Ohio Medicaid Program.
- D) This Agreement supersedes any and all previous agreements for this service, whether written or oral, between the parties.
- E) ODM or its designee may recoup any overpayment by deducting that amount from a current or future payment. Overpayments include, but are not limited to payments made in error, payments for services that were not authorized, payments for services that were authorized but not provided, and payments that were made as a result of inaccurate billing.
- F) 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 Provider, upon receipt of written notice of

termination, shall immediately cease provision of services under this Agreement unless otherwise directed by ODM.

- G) The Provider understands and agrees that no officer, member, employee or agent shall take any 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.
  
- H) The undersigned certifies that he/she is the owner, officer, chief executive officer, or general partner of the organization that is applying to provide services as part of the HOME Choice Demonstration Program. The undersigned agrees to be bound by this Agreement, and confirms that the information he/she has provided is true and accurate.

Name and Title <i>(Please Print)</i>	
Signature	Date

**MAKING  
OHIO  
BETTER**

