

HOME Choice

Transition Coordinator Provider Manual



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

Ohio Department of Medicaid
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INTRODUCTION

“Money Follows the Person” (MFP) is a federal demonstration program established under the Deficit Reduction Act of 2005 and was expanded under the American Care Act of 2010. MFP states are able to access enhanced federal match, for individuals that have transitioned out of institutional settings (Nursing Homes, Developmental Centers etc.) back to the community. The state of Ohio’s MFP program is officially known as “HOME Choice” with each letter representing the purpose: Helping, Ohioans, Move, Expanding Choice.”

The HOME Choice program is unique compared to any other national MFP programs due to its all-inclusive structure. The HOME Choice program serves all populations including: the elderly, people with disabilities, people with mental health diagnoses, infants in children’s hospitals, and youth/teenagers in residential treatment facilities. Nationally, Ohio ranks 2nd in total transitions, transitioning over 6,800 institutionalized individuals back into the community since the program started in 2008 (transition total as of September, 2015). Ohio ranks first nationally in transitioning individuals with mental illness and substance abuse disorders.

This manual was developed to assist Transition Coordinator Agencies in training new staff as well as a tool for existing transition coordinators. Each Transition Coordinator should maintain a provider manual. This manual will help you in the following areas:

- Role and Responsibilities of a Transition Coordinator
- Process of transitioning a HOME Choice participant to the community
- HOME Choice Forms
- Incident Reporting (Protection from Harm)

WHO'S WHO IN THE HOME CHOICE PROGRAM

Below is a list of team members Transition Coordinators work collaboratively with to transition HOME Choice participants into community.

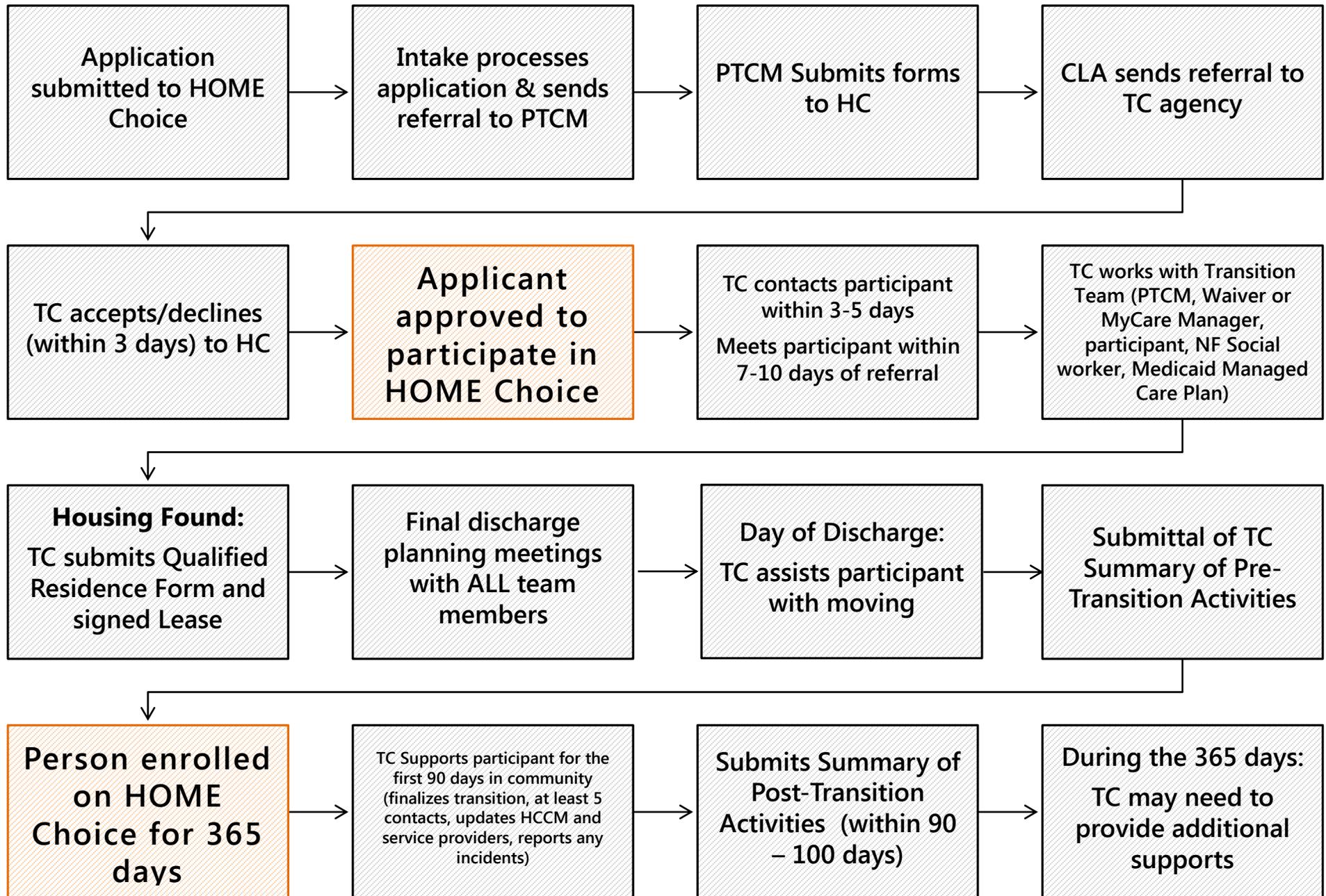
HOME Choice Operations: Ohio Department of Medicaid's administrative entity that manages the HOME Choice Program.

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

HOME Choice Provider Types:

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

TRANSITION COORDINATOR FLOW CHART



HOME Choice Transition Team: Roles and Responsibilities

Transition Team Participation from Pre-Transition through Completion of 365 Days

	Nursing Facility	Pre-Transition	Discharge	Community (1 st 90 Days)	Community (365 Participation Days)
NF Discharge Planner					
Pre-Transition Case Manager (PTCM)					
Transition Coordinator (TC)					
Community Support Coach					
HOME Choice Case Manager					
Managed Care Plans					
MyCare Ohio					
Other HOME Choice Providers					
OhioMHAS Providers					

PRE-TRANSITION PHASE

► **Application Phase** (Prior to TC Selection)

The HOME Choice Application is a single page form that can be filled out by any person. Once the application is completed and signed by the participant or participant's guardian, it is submitted to HOME Choice Operations. HOME Choice Operations then processes the application, assigns the appropriate PTCM for HOME Choice Assessment and forwards to the appropriate CLA based on population.

► **PTCM Assessment Phase** (Selection of TC)

The PTCM meets with the applicant, to review documents and complete the following forms and assessment:

- Eligibility Checklist
- Informed Consent
- Community Readiness Tool

The PTCM decides whether or not to recommend the applicant for the program. If applicant is recommended, the PTCM assists with the selection of a TC agency. The PTCM submits all forms and documents to HOME Choice, including the Service plan naming the selected TC agency.

The CLA reviews all submitted documents and makes the final determination regarding the individual's participation. A TC referral is made to the TC Agency with the following information:

- "Consumer Report" containing application and Eligibility Checklist information
- Informed Consent
- Community Readiness Tool

► **TC Pre-Transition Phase**

The TC agency decides to accept or decline a referral and to HOME Choice Operations within three business days. The CLA authorizes the TC on the HOME Choice Demonstration and Supplemental Service Plan and emails the authorization to the TC and PTCM. This email is titled the "First Deliverable Authorization" email which generates the first deliverable payment to the TC agency.

The TC shall:

- Contact the applicant or guardian by phone within three to five business days of date of authorization.
- Complete the initial face-to-face meeting with the applicant and guardian, if appropriate, within seven to ten business days of authorization.
- Ensure the service plan authorization has been received prior to the initial face-to-face meeting.

TC preparation for the initial face-to-face meeting:

- Review all forms and documents received with the original referral
 - "Consumer Report"
 - Informed Consent (IC)
 - Community Readiness Tool (CRT)
- Print copy of Relocation Handbook from the HOME Choice website
- Gather appropriate community resources

At the initial face-to-face meeting **the TC is responsible for developing a “helping” relationship with the participant**; outlining the TC’s role to the participant and obtaining a good understanding of the participant’s current and future needs. It is recommended that the TC use the CRT and/or the Relocation Workbook to guide discussion. Upon conclusion of the meeting the TC should know the following information and much more:

▶ **Health and recovery status**

- What caused current admission?
- Is there a tentative discharge date?
- What recovery is necessary for discharge?

▶ **Informal Support System**

- What family and friends are involved with participant?
- Dependents?

▶ **Income**

- What is the amount and source of income?
- Any outstanding debt?
- Will JFS benefits need to be coordinated?

▶ **Housing status**

- Does participant have a home?
- Need assistance finding a home?
- Have an eviction history?
- Have a criminal history that needs to be considered in finding housing?

▶ **Community needs**

- Does the participant have community mental health needs?
- Does the participant have community addiction service needs?
- Other assistance needs?

▶ **Transition Plan**

- Develop priorities
- Develop a tentative schedule with the participant (Regular contact is required.)
- Provide participant with TC contact information
- Update the PTCM on the outcome of the meeting
- Develop a contact schedule and format with the PTCM

► Budgeting

A top priority after the initial face-to-face meeting is the development of a **Transition Budget** and a **Community Budget** (next page). These budgets are very different, and each are outlined below.

The **TRANSITION BUDGET** considers what expenses will be paid with the participant's Transition and Transportation Funds. The transition budget should include the following items (*Please refer to Estimated Use of Transition Funds Worksheet*):

- Security Deposit and 1st month rent
- Rental Application Fees
- Debt Repair
- Bank Account & Fees
- Birth Certificate, Social Security card (If needed)
- Household Items
- Kitchen Items
- Start-up Groceries
- Utility Deposits & Installation fees
- Furniture

Community Transition Services

GOODS & SERVICES: The HOME Choice participant has up to \$2,000 available towards expenses and purchases. These funds are administered by the TC and may be used for application fees, rent deposits, utility startups and more. Remaining funds can be used for transitional start up items. Careful planning and consideration of the use of these funds is critical. (*Please refer to the Goods & Services Guidelines*)

Transitional start up items examples are below. The TC should get prior approval from the CLA for items or expenses not on this list and considered more unusual in nature.

- Birth Certificate, and Photo ID
- Security deposit and 1st month's rent
- Start-up utilities (Water, electric, phone etc.)
- Household items: kitchen utensils, linens and towels
- Furniture
- Cleaning supplies
- Start-up groceries
- Moving expenses
- Clothing
- Kids/infants items MUST receive prior approval from CLA

Funds are not typically used for the purchase of entertainment items only.

The TC should not begin shopping for furnishings and supplies until a discharge date is set and is within about three weeks' time. Startup groceries and perishables may need to be purchased on the day of discharge.

PRE-TRANSITION TRANSPORTATION FUNDS: The HOME Choice participant has up to \$500 to be used for transportation purposes. This can include the following: *(Please refer to the Pre-Transition Transportation Guidelines):*

- Housing appointments
- Transportation to obtain ID
- Social Security Administration Office
- Doctor Appointments in the first 30 days post transition
- Other transportation needs in the first 30 days post transition

PAYMENT REQUEST FORM

This form is used when the TC agency is seeking reimbursement for expenses paid or items purchased on behalf of the participant. All reimbursements should be submitted within two weeks of the date of the expenditure. *The TC will complete this form and submit to Morning Sun along with the following items:*

- Copies of receipts
- W-9 if necessary

When seeking reimbursement for security deposit and 1st month rent, the TC will submit the *Combined Residence Verification Document, Security and 1st Month's Rent Form* for reimbursement.

The **COMMUNITY BUDGET** includes realistic estimates of monthly expenses and income. The sample below (Figure 1.1) can be used for the development of this budget or use a budgeting tool preferred by your agency. Consider the following as you work with the individual on their community budget:

- Will the individual have a Medicaid spenddown? The community budget will need to include this information as enrollment in Medicaid is a requirement of HOME Choice participation.
- Can they manage their own money management needs? (Will informal assistance or a payee be necessary?)
- How much rent can they afford? (Rent should be no more than 1/3 of their monthly income.)
- How much can they afford to pay towards utilities? (Will utility assistance programs be necessary?)
- What are the expected monthly expenses for medication co-pays and doctor visits?
- What are the expected monthly transportation expenses? (Bus Pass, taxi?)
- If a payee is needed, what will be the monthly fee?

Figure 1.1

PERSONAL MONTHLY BUDGET

PROJECTED MONTHLY INCOME	Income 1	\$800.00
	Extra income	\$0.00
	Total monthly income	\$800.00
HOUSING	Projected Cost	Actual Cost
Mortgage or rent	\$300.00	\$300.00
Phone	\$20.00	\$25.00
Electricity	\$44.00	\$56.00
Gas	\$22.00	\$28.00
Water and sewer	\$8.00	\$8.00
Waste removal	\$10.00	\$10.00
Maintenance or repairs	\$23.00	\$0.00
Other	\$0.00	\$0.00
Subtotal	\$427.00	\$427.00
TRANSPORTATION	Projected Cost	Actual Cost
Bus/taxi fare	\$35.00	\$35.00
Other	\$0.00	\$5.00
Subtotal	\$35.00	\$40.00
FOOD	Projected Cost	Actual Cost
Groceries	\$75.00	\$75.00
Cleaning Supplies	\$25.00	\$15.00
Other	\$0.00	\$10.00
Subtotal	\$100.00	\$100.00
PERSONAL CARE	Projected Cost	Actual Cost
Medical	\$100.00	\$100.00
Clothing	\$30.00	\$25.00
Toiletries	\$10.00	\$20.00
Personal Items	\$0.00	\$20.00
Other	\$0.00	\$0.00
Subtotal	\$140.00	\$165.00
TOTAL PROJECTED COST		\$702.00
TOTAL ACTUAL COST		\$782.00

► Housing Responsibilities

Participant's housing assistance needs varies greatly from individual to individual. Some participants are independent and capable of locating and evaluating housing options with little TC assistance and other participants require assistance every step of the way. It is the TC's responsibility to assess the level of housing assistance required by the individual and provide the assistance necessary. The TC will provide assistance with some or all of the following tasks:

- Provide list of housing options considering participant's income and location requirements
- Provide guidance on housing options when there is a history of eviction or a criminal background
- Assist in contacting properties/Property Managers
- Accompany the individual to view apartments, when appropriate
- Arrange transportation to potential housing options.
- Assist in securing housing

Once the participant decides on a residence, it is the TC's responsibility to the following time sensitive tasks:

- Assist the participant with applications and fees
- If approved, place a security deposit on the residence
- Notify the PTCM that housing is found
- Submit the HOME Choice Transition Coordination Qualified Residence Statement Form to HOME Choice Operations which includes the statement: "By checking this box, I verify that, as the Transition Coordinator, I have determined that the address on this form meets the HOME Choice Qualified Residence criteria and meets the needs of the participant." **(Required)**
- Submit the lease once it has been signed to HOME Choice Operations or HOME Choice Combined Residence Verification and Security Deposit and 1st Month rent Form

Submission of the *Qualified Residence Statement Form* and the signed Lease will authorize the payment of the 2nd deliverable to the TC agency.

FOR INSTANCES WHERE THERE IS NO LEASE, submission of the *Qualified Residence Statement Form* and the *Combined Residence Verification and Security Deposit and 1st Month Rent Document* will authorize the payment of the 2nd deliverable to the TC agency.

HELPFUL HINT: DOCUMENTATION

LEASE AGREEMENT vs. NO LEASE AGREEMENT

A. LEASE AGREEMENT

Qualified Residence Form + Lease Agreement provides verification that the leased unit used has been inspected and approved by the TC to meet the requirements of a qualified residence. Lease Agreement is used when there is a signed a lease for a rental unit or home. Items to review prior to submission:

- TC must complete the entire Qualified Residence Statement form to indicate the type of qualified residence.
- TC is required to indicate that the home meets the qualified residence criteria designated at the bottom of the form.
- Ensure the Lease has been signed.
- Submit the Lease to HOME Choice Operations (not Morning Sun)

Submission of the Qualified Residence Statement Form and the signed Lease will authorize the payment of the 2nd deliverable to the TC agency.

B. NO LEASE AGREEMENT

Qualified Residence Form + HOME Choice Combined Residence Verification and Security Deposit and 1st Month Rent provides verification that the unit has been inspected and approved by the TC to meet the requirements of a qualified residence. This form is used when there is no lease agreement (i.e. when moving into the home of a friend or family member). It is also used to seek reimbursement for the 1st month rent and security deposit.

The TC Shall: If the individual is moving back home, or in with family/friends and there is no lease, it is required that the TC follows certain guidelines to ensure the sustainability of the participant and those living in the same residence. The guidelines are:

- Hold a meeting with all parties to ensure all agree that the participant may move into the home.
- Visit and verify the home is accessible for the HOME Choice participant.
- Inform family/friends the responsibility to alert the property management (If the home is a rental) of the change in household composition.
- Obtain all pertinent signatures on the HOME Choice Combined Residence Verification, Security Deposit & 1st Month Rent request.
- When speaking to the landlord/family/friends it is good practice to remind them if the housing situation does not work out, the funds should be returned to the appropriate entity to be able to help the participant with other housing options in the future.

In instances where there is no lease, submission of the Qualified Residence Statement Form and the Combined Residence Verification and Security Deposit and 1st Month rent document will authorize the payment of the 2nd deliverable to the TC agency.

► On-Going Transition Planning Responsibilities

The TC needs to be in constant two-way communication with the other members of the participant's transition planning team in order to keep all team members current on the various aspects of the discharge plan. The transition team may include the following:

- Individual and/or the individual's guardian
- Involved family member as selected by the participant
- PTCM
- NF Social Worker or discharge planner
- MyCare Care Manager, if appropriate
- Medicaid Managed Care plan worker, if appropriate
- Community Support Coach, if appropriate
- Other people as dictated by the participant's situation

Multiple discharge planning meetings may be needed to optimize coordination and collaboration with the TC and the team. The entire team needs to be current on all the following:

- Anticipated discharge date
- Medicaid Status
- Waiver status (Waiver assessment and waiver approval is time sensitive. Referrals need to be made with careful attention to the anticipated discharge date.)
- Income status (Has SSI/SSDI been approved?)
- Employment assistance
- Participant's therapy and health status
- Housing status
- Current behavior problems or issues with the NF

WHAT TO DO IF PARTICIPANT IS GIVEN A 30 DAY NOTICE OR LESS

From time to time a HOME Choice participant is given notice to vacate the nursing home prior to the completion of the discharge planning process. When this happens, the first step is to determine what is the cause for the notice.

This will help determine how to proceed. Below are suggested actions that can be taken.

- Contact the CLA and the PTCM immediately to make them aware of the situation
- Engage the support of the local Long-term Care Ombudsman, if appropriate
- Assist the participant with rejecting the proposed discharge date with the NF administration in order to appeal the notice, if applicable
- Request NF social worker or discharge planner to negotiate an extension with the managed care organization
- Make the case a top priority and creatively explore alternative options to discharge the individual in the safest manner possible.

DISCHARGE PHASE

The final discharge planning phase begins when the participant has secured income and housing or the NF is insisting on a more immediate discharge date due to notification from a Medicaid Managed Care or MyCare plan. A discharge planning meeting or several discharge planning meetings with the team should be arranged to discuss the dates and task assignments. The discharge planning team will include all of the people who were included in the on-going discharge planning meetings and also include the waiver case manager or the HOME Choice case manager from CareStar, if the participant is not enrolling on a waiver.

The NF social worker/discharge planner is responsible for discharge planning and should be included in the meetings held at the facility for easy access to the participant. This coordination and collaboration will help ensure the individual has a smooth transition.

► Transition Planning Meetings

The focus of the meetings shifts in this final phase of transition planning to ensure all of the community-based services will be in place on the day of discharge. Below is a list of some of tasks to be assigned to members of the transition team. Many of the tasks are responsibilities of the NF social worker/discharge planner, but should be discussed to ensure consensus on task assignment:

- Status of Social Security Income (SSI)
 - Coordinate to have checks sent to new address
 - If there is a payee, seek new community-based payee
- Status of home & community-based waiver services, if appropriate
- Utility assistance (HEAP, PIPP etc.)
- Ensure community-based services are approved/authorized (home health services)
- A community physician has been located and an appointment made
- Assist with setting up a bank account
- Assist participant with choosing a Managed Care Plan, if appropriate
- Assist with linkage to behavioral health agency
- Confirm how much medication the participant will discharge with and ensure there are prescriptions for the community
- Assist with establishing a local pharmacy
- Order any assistive medical/durable equipment to have available upon discharge
- Arrange/schedule: Nursing, Home Health aide and therapy referrals
- Discharge transportation necessary, if needed

If it is **determined that needed services cannot be put in place in time for discharge**, the team might explore the option of delaying the discharge date. Another option is to speak with the CLA to determine if certain HOME Choice services can be added to bridge the gap until community-based services can be authorized. HOME Choice services that may be added in this situation include the following:

- HOME Choice Nursing Services
- HOME Choice Case Management (If Waiver is still Pending)
- Community Support Coaching
- Independent Living Skills Training Specialist

► Final Discharge Planning Meeting

- All planning lists should be complete with services in place for a smooth transition into community.
- Meeting should be held within one week of the discharge date and scheduled well in advance to ensure the HOME Choice Team (PTCM, HCCM, TC, and Nursing Home Discharge Planner), family etc. can attend.
- Review the status of all assigned tasks or issues associated with the completion of assigned tasks.
- Identify any outstanding tasks.
- Verify that services are in place and service agencies are scheduled to begin providing those services.
- Utilize the Transition Coordinator Planning Document/To Do Checklist as a guide in this meeting.

► Day of Discharge

The day of discharge is a celebratory occasion for the HOME Choice participant. It is exciting to leave the facility, see a new home, and transition back into community. However, it can be an uneasy time also. Leaving the security of a nursing facility or other institution and dealing with the issues and isolation with living independently can cause anxiety. The completion of the following tasks lessens the stress associated with returning to the community.

- Accompany HOME Choice participants to their home, if appropriate
- Purchase start-up groceries and household items
- Set up all furniture in the home
- Obtain medication from the nursing home
- Access to a working phone
- Change of Address at local County JFS, SSA offices, post office
- Supply a provider contact list (Agency, Name, Phone number, HCCM contact information etc.) for HOME Choice participant
- Ensure waiver or state plan providers will show up as expected
- Disseminate new address to all pertinent providers

SUMMARY OF PRE-TRANSITION COORDINATION ACTIVITIES FORM

The HOME Choice Summary of Pre-Transition Coordination Activities form is used to report data on the work that has taken place during the pre-transition phase of the individual's transition.

- This forms needs to be submitted the day after discharge and is required in order for the CLA to authorize the 3rd deliverable.
- DO NOT LEAVE ANY FIELDS BLANK

POST-DISCHARGE PHASE

The TC continues to be involved with the participant 90 days post-discharge and is responsible for any transitional activities that have not been resolved. This continued involvement is to identify needs and resolve them to avoid re-institutionalization. Below is a list of items that often require further follow up by the TC.

- Resolve pending transition tasks.
- Income status? Coming to participant's home/bank?
- Prescriptions have been successfully filled by community pharmacy?
- Bills are being paid on time and fully
- Revisit the participant's budget and modify accordingly
- Ensure waiver or home health services have been initiated, as appropriate
- Linkages were made to community mental health or addiction service, as appropriate
- Assess how the participant is adjusting emotionally to the transition/move
- Determine if supplemental services are needed
- Maintain contact with participant's Waiver, MyCare or HOME Choice case manager
- If no case manager is involved, contact the CLA
- Maintain contact with the CLA
- Report all incidents to the case manager

TC Responsibilities End at 90-Days

The TC's role with the participant officially ends when the participant has completed 90-days in the community. The TC is responsible for making the participant aware that their involvement is over and who to call in the future (case manager) when issues arise. It is recommended that the TC and the participant's case manager meet with the individual together prior to the 90th day to have a concluding TC visit. The purpose of the visit is to discuss any on-going issues that the case manager will be responsible for follow up.

Though the TC role is completed at 90-days, if at any time during the 365-day demonstration period the participant is in need of assistance from the TC, the CLA, can request the TC to step in and provide further assistance. Below is a list of possible reasons why a TC may be requested to assist:

- Re-Application of a HOME Choice Participant
- Housing Crisis
- Use of additional Transitional Services funds (use of Goods & Services as approved by the CLA)

SUMMARY OF POST-TRANSITION ACTIVITIES FORM

- The TC will have at least 5 contacts with the participant:
 - At least two contacts must be face to face
 - Day of discharge does not count towards contacts
 - Be sure to visit a few days after discharge.
 - Final visit should be close to the 90th day
- At least one face-to-face meeting with the HCCM is needed to ensure all "Pre-Transition" tasks are completed and determine if any additional services should be added.
- Form must be filled out entirely
- Participant must be **in** the community for 90 days (Institutional days to not count)
- **A minimum of five forms shall be submitted between the 91st and 100th day the individual is in the community**

CHANGE IN STATUS FORM

The Change in Status form alerts the CLA when there is a change in the condition, living arrangement, etc. for each person. Either the TC, HCCM or waiver case manager submits this form. If the TC submits a Change in Status form, the case manager needs to be informed of the situation. Below are examples for submission:

- Prior to discharge when a participant decides to no longer participate in the program (called pre-enrollment termination)
- If the TC and the PTCM decide together that prior to discharge a participant is no longer appropriate for the program (called pre-enrollment termination)
- If the enrolled HOME Choice participant is admitted to an institution (hospital, nursing facility etc.), discharged or transferred to another institution.
- If the TC and the case manager decide together that the participant is not abiding by the responsibilities outlined in the Informed Consent and are recommending disenrollment from the program
- If the TC and the case manager decide together that the participant's health and safety cannot be assured in the community and are recommending disenrollment from the program
- Moves to a new location/residence
- Others? Look at the form to decide

HOME Choice Participant Continues until Disenrollment

While the role of the TC may have ended, the individual continues in the program with HOME Choice Services and other Medicaid services. However, a HOME Choice participant may be disenrolled for the following reasons prior to 365-days:

- Individual is hospitalized for more than 60 days.
- Individual refuses to participate
- Individual asks to be removed from the program

HOME CHOICE FORMS AND TOOLS

TC's are responsible for submitting a variety of forms and tools to HOME Choice Operations. The use and instructions for some of the TC forms have been included in this manual in shaded information boxes. The purpose of the inclusion of these instructions was to inform the TC of the events that trigger the necessary completion and submission of certain forms.

Instructions for the completion of other TC forms can be found on the website, in a document entitled HOME Choice Forms and Tools Instruction Guide ([HOME Choice Forms and Tools Instruction Guide](#)).

The timely submission of all forms is expected and very important. The HOME Choice website contains the latest version of each form or tool. *Do not print out forms or tools in advance as they are subject to frequent changes.* An email communication will be sent to all providers when there is a change to any form.

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
- Service Claim Tool
- Summary of Post-Transition Activities
- TC Planning Document / To-Do Checklist
- TC Relocation Workbook
- Transportation Funds Guidelines

RESOURCES

Additional resources and documents are available for Transition Coordinators on the Training Updates page of the HOME Choice website at medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice/TrainingUpdates.

Some of the most commonly used resources are linked below:

- 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

Local Community Resources:

Use this section to collect information about community resource and contacts that will benefit HOME Choice participants. Possible resources could include food banks, furniture banks, free stores, utility assistance organizations, county assistance programs, employment resources, transportation services, etc.