

Ohio Department of Medicaid
OHIO HOME CHOICE DEMONSTRATION PROGRAM
TRANSITION COORDINATION SERVICE APPLICATION/TIME LIMITED AGREEMENT

Submit completed signed application/agreement with required attachments to

Ohio HOME Choice Demonstration Program
 Provider Application Processing
 P.O. Box 182709
 Columbus, Ohio 43218-2709

<i>(For State Use Only)</i>

Provider Identification *(Please print or type entries)*

Individual Name <i>(First, Middle Initial, and Last) or Agency Name</i>			
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)*

(Please complete an application for each physical location of practice or business. Non-agency providers can use home address if applicable)

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

“Pay to” 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	State		Zip Code <i>(Zip +4, if possible)</i>

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 <i>(Zip +4, if possible)</i>

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

1. Have you or any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or professional association been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX? YES NO

Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN
Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN

3. List names, addresses, AND SSNs for individuals serving in a leadership role (paid or volunteer).

Name	Address	SSN/EIN

6. Are any individuals serving in a leadership role (paid or volunteer) also the owner of other Medicare/Medicaid facilities? If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number. YES NO

Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number

4. Have you or the entity ever been sanctioned by the Medicare or Medicaid Program? YES NO
If "YES", when? (mm/dd/yyyy) How long? (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN

5. Have you or any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, or Organization ever been indicted or convicted of a violation of State or Federal Law? YES NO

Name	Type of Offense and Disposition	When, give date? (mm/dd/yyyy)	SSN/EIN
Name	Type of Offense and Disposition	When, give date? (mm/dd/yyyy)	SSN/EIN

(For State Use Only)

All Transition Coordination Service providers must read the statements below, print name, initial, and date.

In accordance with Executive order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio Ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

Name and Title *(please print)*

Initial

Date

A copy of Executive Order 2007-01S can be found on our website at: <http://medicaid.ohio.gov>

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

Name and Title *(please print)*

Initial

Date

Transition Coordination Services

"Transition coordination services" help HOME Choice participants plan and arrange for services and supports they will need while moving from an institution to the community. Participants have the right to choose from a list of available transition coordination service providers.

Transition coordination services include the following:

1. Education and outreach about HOME Choice in the transition coordination provider's service area.
2. Assisting with the completion of the HOME Choice participant workbook that helps the participant formulate a transition plan, if needed.
3. Participating in team meetings as scheduled by the case manager.
4. Participating in discharge planning from the institutional setting.
5. Arranging, securing or providing transportation for the participant for the purpose of visiting community resources, e.g., to potential housing units or the social security office, or to purchase goods and services, etc.
6. Housing navigation that assists the participant in securing appropriate housing when moving from an institutional setting to a qualified residence.

A. As defined in rule 5101:3-51-01 of the Administrative Code, a qualified residence is:

- i. A home owned or leased by the participant or the participant's family member;
- ii. An apartment with an individual lease, that has lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the participant or the participant's family has domain and control. An apartment includes only the following:
 - (a) A private apartment,
 - (b) A public housing unit, or
 - (c) Certain residential care facility units designated for assisted living; or
- iii. A residence in a community-based residential setting in which no more than four unrelated individuals reside. A community-based residential setting only includes the following:
 - (a) Adult foster homes,
 - (b) Adult family homes,
 - (c) HCBS adult foster care certified by ODMR/DD,
 - (d) Supported living arrangements for individuals with MR/DD who receive services through an ODMR/DD-administered waiver,
 - (e) Non-ICF-MR residential facilities licensed by ODMR/DD,
 - (f) Type 1 residential facilities licensed by the Ohio department of mental health (ODMH),
 - (g) Type 2 residential facilities licensed by ODMH,
 - (h) Foster homes for children that are certified by ODJFS,
 - (i) Medically fragile foster homes for children that are certified by ODJFS,
 - (j) Group homes for children that are licensed or certified by ODJFS.

B. Housing navigation includes:

- i. Assessing housing options that meet the participant's specific needs and preferences, including accessibility needs;
- ii. Helping the participant to identify available, affordable and sustainable housing;
- iii. Assisting with securing housing, by verifying that housing meets the definition of a qualified residence, and verifying licensure and/or type of housing subsidy, as appropriate;
- iv. Assisting the participant with the application process including, but not limited to, securing funds for application fees and security deposits;
- v. Investigating and arranging rental subsidies;
- vi. Helping the participant to understand the ongoing eligibility requirements of a wide range of affordable and accessible public housing;
- vii. Helping the participant to meet and negotiate with prospective landlords;
- viii. Assisting with placement on housing waiting lists;
- ix. Helping the participant to secure information needed to complete applications for housing including, but not limited to:
 - (a) Birth certificate;
 - (b) State identification card; and
 - (c) Social security card;
- x. Working with the participant to overcome housing barriers including, but not limited to:
 - (a) Credit recovery; and
 - (b) Criminal convictions;

- xi. Working with the participant to overcome housing barriers including, but not limited to:
 - (a) Credit recovery; and
 - (b) Criminal convictions;
 - xii. Assessing the need for, and working with the participant to, develop a plan to obtain home modifications;
 - xiii. Assisting the participant with arranging for the connection of utilities;
 - xiv. Assisting the participant with and/or coordinating the actual physical move;
 - xv. Helping the participant to identify needed household items;
 - xvi. Helping the participant find a roommate, if requested;
- C. Benefits coordination that assists the participant in identifying and accessing a broad range of financial, medical and other benefits for which the participant may be eligible, and that will allow the participant to move into, and live safely in, the community.
- i. Benefits coordination includes, but is not limited to:
 - (a) Identifying potential benefits for the participant;
 - (b) Performing benefit analyses to maximize benefits and earned income without jeopardizing eligibility for other benefits;
 - (c) Assisting the participant with the completion of and follow-up on applications for benefits;
 - (d) Assisting the participant with benefit redeterminations and appeals;
 - (e) Helping the participant to establish and follow a budget; and
 - (f) Assisting the participant in establishing a plan to meet ongoing obligations.
 - ii. Benefits include, but are not limited to:
 - (a) Social security;
 - (b) Veterans administration benefits;
 - (c) Medicare;
 - (d) Medicaid;
 - (e) Food stamps; and
 - (f) Local benefits, etc.
- D. Assisting with linkages to employment options, if the participant is interested.
- E. As directed by the participant, assisting in determining the most effective use of funds, the purchasing of available HOME Choice Community Transition Services (goods and services) as described in OAC rule 5101:3-51-04, and the coordination of payment of the Community Transition Services through the financial management service (FMS) contractor;
- F. In consultation with the waiver case manager or ODM care coordinator, as appropriate, and as directed by the participant, assisting in locating community resources such as a physician, pharmacy, etc.; and
- G. If needed, assisting the participant in linking with a managed care plan member selection specialist.

Transition coordination services shall not duplicate independent living skills training or community support coaching services available through HOME Choice. Additionally, transition coordination services shall not duplicate similar waiver or administrative services available on an HCBS waiver on which the participant is enrolled.

Transition coordination services are reimbursed through the entity under contract with ODM to provide FMS for the HOME Choice Program. Up to \$5,000 is available per participant during the 180 days before the individual moves from the institution to the community and the 365 days after they move from the institution to the community. Full and complete reimbursement is contingent upon meeting each of the following deliverables:

- A. \$3,000 payment upon the provider's acceptance of a HOME Choice referral from ODM.
- B. \$1,000 payment upon ODJFS' receipt of documentation from the provider that qualified housing has been secured for the participant.
- C. \$1,000 payment upon ODM' receipt of documentation from the provider that the participant has relocated from an institution into the community.

Acceptable documentation consists of an ODM-approved referral form, an ODM-approved verification of qualified housing/participant relocation form. Documentation of qualified housing may also include a copy of the participant's signed lease agreement.

The sum total of \$5,000 paid in the three deliverable stages noted above represents payment in full for transition coordination services provided to the HOME Choice participant. However, if during the 365-day demonstration period, the participant's living arrangement jeopardizes his or her health and welfare and the participant requires further assistance with housing navigation in particular, the transition coordinator is expected to provide up to eight hours of additional transition coordination services. If housing navigation is needed after the eight hours have been exhausted, the transition coordinator shall work with the participant's case manager to secure prior authorization from ODM for additional service hours. At a minimum, the request for prior authorization must include a detailed housing navigation budget.

In order to submit a payment request for transition coordination services, the provider must submit a statement and required documentation to ODM with the following assertions:

- A. Staff providing direct participant contact have knowledge and experience about local community resources and applicable disability laws and regulations.
- B. Staff providing direct participant contact embrace participant self-determination and possess experience advocating on behalf of individuals with disabilities.
- C. Staff providing direct participant contact are age eighteen or older.
- D. Staff providing transportation for the participant possesses a valid Ohio driver's license and valid automobile liability insurance.
- E. The provider meets the conditions of participation set forth in rule 5101:3-51-03 of the Administrative Code.
- F. The provider is both identified as the transitions coordination service provider, and authorized by ODM on the participant's HOME Choice service plan.
- G. HOME Choice statements shall be submitted to ODM for each deliverable, along with required documentation that supports completion of the deliverable.
- H. The provider shall comply with all of the policies and procedures governing HOME Choice as set forth in HOME Choice operational protocol, and Chapter 5101:3-51 of the Administrative Code.

Transition coordination service providers are required to maintain a consumer case record for each consumer served. At a minimum, the case record must contain:

- A. A consumer cover sheet that includes basic demographic information, i.e., name, address and telephone number of facility where consumer is residing, emergency contacts, guardianship information (if applicable), and name and contact number for waiver or ODM state plan case manager.
- B. Case notes that include documentation of all consumer contacts and contacts or activities the transition coordinator does on behalf of the consumer. Nothing shall prohibit the use of technology-based systems in collecting and maintaining case note documentation. However, the case notes must be dated and signed by the transition coordinator.
- C. Releases of information on HIPAA-compliant forms.
- D. ODM-approved forms used for the tracking of goods and services expenditures.
- E. All copies of the participants' service plans.

Transition coordination service providers are required to conduct and document no less than the following service monitoring activities:

- A. A review of each participant's case record for the purpose of ensuring that the record contains the minimum required documentation.
- B. Monthly face-to-face staff meetings with each of the agency's transition coordinators to discuss the participant's progress.

In addition, questions about transition coordination are included in the HOME Choice quality of life survey that participants will be completing.

The transition coordination provider shall maintain documentation of all service monitoring activities. The documentation must be included in the participant's case record.

(For State Use Only)

Ohio HOME Choice Demonstration Program Transition Coordination Service Provider Agreement [For Transition Coordination Service providers of HOME Choice Demonstration Program (Money Follows the Person) Services]

This provider agreement is a contract between the Ohio Department of Medicaid (the Department) and the undersigned provider of HOME Choice Demonstration Program Transition Coordination services (the Provider) in which the Provider agrees to comply with the terms of this is provider agreement, state statutes, Ohio Administrative Code rules, and agrees and certifies to:

1. Render HOME Choice Demonstration Program services in accordance with Chapter 5101:3-51 of the Administrative Code and as authorized in the HOME Choice Demonstration Program participant’s (the Participant) all service plan, service plan, individual service plan or non-waiver HOME Choice service plan as appropriate, and only in the amount required by the Participant without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department in accordance with rule 5101:3-51-06 of the Administrative Code.
2. Follow all ODM-approved reimbursement policies and procedures established for the HOME Choice Demonstration Program, including timely submission of claims.
3. Accept the allowable reimbursement for all HOME Choice Demonstration Program services as payment-in-full and not seek reimbursement for the services from the Participant, authorized representative, any member of the family, or any other person. Follow all ODM-approved reimbursement policies and procedures established for the HOME Choice Fiscal Management Services (FMS), including timely submission of claims.
4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The Provider shall maintain such records 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.
5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Health Care Fraud Section of the Ohio Attorney General, or their designees, any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of HOME Choice Demonstration Program payments and may result in termination from the HOME Choice Demonstration Program.
6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; additions; deletions, physical, mail-to, pay-to or email address; and phone number.
7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-51-03 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX Services. The provider shall also comply with the criminal record check requirements set forth in Rule 5101:3-51-03 of the Administrative Code.
8. Neither the non-agency provider, nor the organization, nor any owner, director, officer, employer of the organization, or any non-agency provider retained by the organization or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.
9. Follow the regulations and policies set forth in Chapter 5101:3-51 of the Administrative Code.
10. Provide to the Department, through the court of jurisdiction, notice of any action brought by the Provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to the **Office of Legal Services, Ohio Department of Medicaid 50 W. Town Street – 4th Floor, Columbus, Ohio 43215.**
11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of HOME health care and personal care services, hospices, HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d), and Chapter 5101:3-51 of the Administrative Code.

This agreement may be canceled by either party upon written notice to the other party no less than 30 days prior to the termination date.

I further certify that I am the non-agency provider who is applying for approval to provide HOME Choice Demonstration Program Services, or in the case of an organization, I am the officer, chief executive officer, or general partner of the organization that is applying for this HOME Choice Demonstration Program provider agreement. I further agree to be bound by this agreement, and certify that the information I have given on this application is true and accurate.

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.

This agreement is limited to the duration of the HOME Choice Demonstration Program, and will thereby end on September 30, 2012.

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