

Ohio Department of Medicaid
HOME CHOICE - SUMMARY OF PRE-TRANSITION COORDINATION ACTIVITIES

Date

Participant Name <i>(Last, First, MI)</i>
Participant Medicaid ID # <i>(12 digits)</i>
Transition Coordinator Name
Transition Coordination Agency/ HOME Choice Provider Number

All questions must be answered for CMS reporting purposes. *The data may be “approximations” where applicable. Submit this form to HOME Choice Operations Unit **within 10 business days** following the participant’s transition to the community.*

IF THE PARTICIPANT DOES NOT TRANSITION TO THE COMMUNITY, complete the **ENTIRE** form, **including** the additional section on page 3.

Submission of this form and the lease when the person enrolls is required for payment of the 3rd deliverable.

If the transition coordinator was the referral source, indicate identification strategies resulting in referral. <i>(Check all that apply.)</i>	<input type="checkbox"/> Visits to NF/ICF- IID/Hospital <input type="checkbox"/> Use of data source to locate participants <input type="checkbox"/> Media – flyers posted <input type="checkbox"/> Other <i>(Please specify.)</i> <input type="checkbox"/> Not applicable
How involved was the family in the transition coordination process?	<input type="checkbox"/> Very involved <input type="checkbox"/> Somewhat involved <input type="checkbox"/> Not involved at all <input type="checkbox"/> Not Applicable
How involved was the guardian in the transition coordination process?	<input type="checkbox"/> Very involved <input type="checkbox"/> Somewhat involved <input type="checkbox"/> Not involved at all <input type="checkbox"/> Not Applicable

For the following questions, enter -0- where no time was spent on the activity.

How many team meetings did the Transition Coordinator attend?	(insert #) with pre-transition case manager (insert #) with facility discharge planner
How many hours spent on benefits coordination?	(insert approximate # of hours)
How many hours spent coordinating goods and services?	(insert approximate # of hours)
How many hours spent on initial coordination of managed care?	(insert approximate # of hours)
How many hours spent coordinating home modifications/ adaptations?	(insert approximate # of hours)
How many hours spent linking participant to community resources?	(insert approximate # of hours)
How many hours spent on date of discharge?	(insert approximate # of hours)

Participant Name (Last, First, MI)	
Was the participant linked with employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No – participant not interested in employment <input type="checkbox"/> No – participant interested but not linked
If Yes to the above question, indicate date of referral to employment assistance and referral source. (Check all that apply.)	<input type="checkbox"/> Disability Employment Initiative → <i>Date of Referral</i> <input type="checkbox"/> Opportunities for Ohioans with Disabilities Agency Referral → <i>Date of Referral</i> Likely to Receive Personal Care <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Services through DD delivery system → <i>Date of Referral</i> <input type="checkbox"/> Senior Community Service Employment Program → <i>Date of Referral</i> <input type="checkbox"/> VA → <i>Date of Referral</i> <input type="checkbox"/> Other (Please specify)
Provide total transportation costs expended as a result of transition activities as well as method (public transportation, personal car etc.) <u>If no transportation costs please enter \$0.00.</u>	Method(s) used Approximate Amount of Funds Spent \$
What difficulties did the participant have in accessing services? (Check all that apply.)	<input type="checkbox"/> Insufficient supply of providers <input type="checkbox"/> Insufficient supply of direct care workers <input type="checkbox"/> Pre-authorization requirements <input type="checkbox"/> Limits on amount, scope and duration <input type="checkbox"/> Lack of transportation options or unreliable transportation <input type="checkbox"/> Insufficient availability of HCBS waivers <input type="checkbox"/> None/Not Applicable <input type="checkbox"/> Other (please specify)
What were the overall barriers to transition? (Check all that apply.)	<input type="checkbox"/> Provider referral or cooperation <input type="checkbox"/> Lack of interest among participant and/or family members <input type="checkbox"/> Participant unwilling to consent to program requirements <input type="checkbox"/> Could not locate housing <input type="checkbox"/> Could not secure affordable housing <input type="checkbox"/> Participant did not choose a qualified residence <input type="checkbox"/> Participant changed his/her mind and would not cooperate in plan development <input type="checkbox"/> Service needs are greater than could be provided safely in the community <input type="checkbox"/> Participant too ill <input type="checkbox"/> Guardian refused <input type="checkbox"/> None/Not Applicable <input type="checkbox"/> Other (please specify)

Participant Name <i>(Last, First, MI)</i>		
Complete this entire form, <i>including the section below</i>, if the participant never discharges from the institutional setting and is recommended for pre-enrollment termination from HOME Choice.		
Amount of time in the pre-discharge transition phase before decision was made to take the participant off of the approval list.	Number of Days	
Provide details and/or barriers that resulted in the decision to take the participant off of the HOME Choice approval list.		
If goods and services were purchased prior to the decision to take the participant off of the HOME Choice approval list, please provide final disposition of goods and services.		
<input type="checkbox"/> Not Applicable <input type="checkbox"/> Final Disposition of Goods & Services <i>(Describe)</i>		
If housing is secured prior to the decision to take the participant off of the approval list, please provide disposition of housing.		
<input type="checkbox"/> Not Applicable <input type="checkbox"/> Final Disposition of Housing <i>(Describe.)</i>		
Form Completed by Name	TC Agency	Phone Number

Submit this form to:

HOME Choice Operations Unit
Ohio Department of Medicaid/ Bureau of Long-Term Care Services and Supports
PO Box 182709, 5th Floor
Columbus, OH 43218-2709

E-Mail: HOME_Choice@medicaid.ohio.gov

Phone: 888-221-1560

Fax: 614-466-6945