

Ohio Department of Medicaid
HOME CHOICE - INFORMED CONSENT

Participant Name (<i>Last, First, MI</i>)	Medicaid ID# (<i>12 digits</i>)
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RIGHTS AND RESPONSIBILITIES OF PARTICIPATION

I understand and agree to the following requirements for participation in the Ohio HOME Choice program:

I will move from the nursing facility, ICF/IID, hospital or residential treatment facility to a qualified community residence. A qualified community residence is:

- A residence owned or leased by me or my family; or
- A residence in the community in which no more than 4 unrelated people reside.

I will have resided in a nursing facility, ICF/IID, hospital and/or residential treatment facility at least 90 consecutive days before I move.

I will have at least one Medicaid claim prior to my move.

I will receive Pre-Transition Case Management services from HOME Choice that will include:

- An assessment of my community living potential;
- A review of services & resources available in the community through HOME Choice, waivers and/or Medicaid; and
- Assistance with community transition planning.

I will receive Transition Coordination services from HOME Choice that may include:

- Help initiating the process to apply for benefits such as SSI and food stamps;
- Help finding a place to live;
- Help finding a doctor, pharmacy and other community resources; and
- Help buying things I'll need to get set up in the community
 - Up to \$2,000 of HOME Choice transition funds may be used for furniture, start-up groceries, personal items, application fees for apartments, security deposits, etc. Funds cannot be used for electronics, uniforms or memberships.
 - Up to \$500 may be used for pre-transition transportation expenses.

I must be Medicaid eligible to receive services from a Medicaid waiver or from Medicaid State Plan upon discharge from the facility to a qualified community residence and must be Medicaid eligible during the 365 days of participation in the HOME Choice program.

My HOME Choice service plan and health outcomes will be monitored and reviewed by representatives from the HOME Choice program.

I understand that my HOME Choice services will be available for up to 365 days of participation in the program. After my 365 days of participation in HOME Choice ends, I may continue to receive waiver or Medicaid state plan services as long as I meet the eligibility requirements.

I understand and agree to the following responsibilities as a participant in the Ohio HOME Choice program:

- I will actively participate in any assessments and/or meetings necessary to develop a service plan that assures my health and safety, and I will meet with my transition coordinator and pre-transition/post-transition case manager before and after my transition. Failure to do so may result in my termination from the HOME Choice process;
- My participation in the HOME Choice program may be terminated if my health and safety cannot be assured in the community;
- If I leave the facility against medical advice and/or prior to participating in plans to ensure a safe and orderly discharge to the community, I may forfeit the opportunity to participate in HOME Choice;

RIGHTS AND RESPONSIBILITIES OF PARTICIPATION (*continued*)

Participant Name <i>(Last, First, MI)</i>		Medicaid ID# <i>(12 digits)</i>
<ul style="list-style-type: none"> I will provide full and accurate information (e.g. credit history, law enforcement involvement, rental history, personal history) to my HOME Choice providers so they may appropriately plan for and assist me with my transition to a community setting; My refusal to participate and follow my service plan may result in my termination from the HOME Choice program; I will meet and communicate with representatives from the HOME Choice program for up to two years after I discharge from the facility and I will be required to participate in a Quality of Life Survey before and after I have been enrolled in the program; and I will promptly notify the HOME Choice program if I move during the follow-up period and will provide them with my new contact information. <p><i>I understand that enrollment in the HOME Choice program is voluntary, therefore:</i></p> <p><input type="checkbox"/> I agree to participate in the HOME Choice program and understand that information obtained by approved HOME Choice providers (Community Living Specialists, Pre-Transition Case Managers, etc.) may be shared with additional HOME Choice providers as part of my transition planning.</p> <p><input type="checkbox"/> I do not want to participate in the HOME Choice program at this time. I understand that I may reapply for HOME Choice at a later date. This decision does not impact the services I am currently receiving.</p>		
Applicant Signature <i>(or mark)</i>		Date <i>(mm/dd/yyyy)</i>
Guardian Signature		Date <i>(mm/dd/yyyy)</i>
Witness Signature <i>(if applicant is only able to make a mark)</i>		Date <i>(mm/dd/yyyy)</i>
Witness Relationship to Applicant	Address	
Pre-Transition Case Manager Signature		Date <i>(mm/dd/yyyy)</i>
Applicant Name <i>(Last, First, MI)</i>		
GUARDIAN'S RESPONSIBILITIES		
<p>As guardian of the person for someone participating in the HOME Choice Program, I agree to do the following:</p> <ul style="list-style-type: none"> Participate in discharge planning Be available to participate in service planning meetings Comply with all probate court required reporting requirements 		
Guardian Signature		Date

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