

# HOME Choice Service Provider Spring 2015 Training

9:00 – 4:00

## Morning Session 9 – 11:30

- Welcome, Introductions:
- What is our purpose (Vision & Goals)
- HOME Choice Program Overview
- HOME Choice Work Flow
  - HOME Choice Referral Process for Service Providers
  - HOME Choice Supplemental & Demonstration Service Plan Document
  - HOME Choice Service Claim Form and Supporting Documentation
  - Review Morning Star website and Portal

### **BREAK**

- Protection From Harm Review

**LUNCH ON YOUR OWN 11:30 – 12:30**

## Afternoon Session 12:30 – 4:00

- HOME Choice Provider Agreement & Rules (OAC)
- HOME Choice Website Review
- **Case Study Breakout Sessions**
  - Small group case study of a typical HOME Choice Participant lead by the HOME Choice Case Manager
- What can we do better
- Wrap Up & Evaluations
- Safe Travels! Thank you for being here!!



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

Participant Name and Contact Information Bill (Last Name)  Phone: xxx-xxx-xxxx Guardian: Guardian Phone:	<b>Medicaid #: xxxxxxxxxxxxxx</b>  Participant Start Date: 8/22/2013 <b>(HC APPROVAL DATE)</b> Participant End Date: CLA: Karen Jackson <b>(1)</b> Case management Agency: CareStar, Bobbie Malone MyCare Ohio Plan:
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Date(s) Begin and/or End date	HOME Choice Service Code	Unit(s) Date Span	Cost	HC Provider Number/ Provider Name, Phone
8/2/2013 – 1/8/2014	HC018 – Pre-Transition Case Management	1	\$0.00	HC1609 – CareStar, Inc., 800-616-3718
9/4/2013 –	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>(2)</b>	HC003 – Independent Living Skills Training	576 <b>(3)</b>	\$0.00	HC1512 - Jefferson Behavioral Health
1/14/2014 – <b>(2)</b>	HC004 – Community Support Coaching	288 <b>(4)</b>	\$0.00	HC1512 - Jefferson Behavioral Health
1/14/2014 – <b>(2)</b>	HC005 – Social Work/Counseling Services	144 <b>(5)</b>	\$0.00	HC1512 - Jefferson Behavioral Health
1/30/2014 - <b>(2)</b>	HC007 – Communication Aides	1	\$0.00	HC1016 – WYNN-REETH, INC, 419-639-2094

- (1) The HOME Choice Community Living Administrator**
- (2) Begin Date authorizing HOME Choice Service Providers for the designated service**
- (3) Number of units authorized for Independent Living Skills Training (1-Unit = 15 minutes)**
- (4) Number of units authorized for Community Support Coaching (1-Unit = 15 minutes)**
- (5) Number of units authorized for Social Work Counseling (1-Unit = 15 minutes)**

- **Services cannot begin prior to the Service Authorization Begin Date.**
- **Services cannot continue beyond the Service Authorization End Date.**
- **PTCM or HCCM responsibility to contact service providers prior to SP submission: Will ask; Will you work with this person?**
- **All providers get emailed revised Service Plans when they are updated by HOME Choice Operations.**
- **CSC is the only service that can be added prior to discharge.**

**HOME Choice Operations Unit  
 Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports (BLTCSS)  
 Phone: 888-221-1560 or Fax: 614-466-6945 or Email: HOME\_Choice@medicaid.ohio.gov**

# **Mock Service Authorization Email**

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.**

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Ohio Department of Medicaid  
**HOME Choice-SERVICE CLAIM**

<b>HOME Choice Service Code</b>	<b>Service Name</b>	<b>Maximum Units/Hours Allowed</b>
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 - total respite service
HC013	Out-of-Home Respite Service	\$2,000 - total respite service
HC014	Camp Respite Service	\$2,000 - total respite service

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

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 <u>if participant is discharged from a facility back into the community OR moves from one qualified residence to another after enrollment into the program.</u> <b>All fields are required information.</b></i>				
Move Type			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 (Last, First, MI)	Medicaid ID # (12 digits)
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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 (Describe.)
	<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 (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

**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

# **Mock Disenrollment/Termination Email**

**The HOME Choice participant, Eddie Rodgers, 104080018599, was disenrolled from program participation on 4/6/2015.**

A notice of the disenrollment was mailed to the participant on 04/06/2015.

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**(1)** Notification the HOME Choice Participant is dis-enrolled/Terminated.

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