

**Staff Training Manual
for the
Nursing Home Transition Program
and
Money Follows the Person/Rhode to Home**

Version 1 November 2012

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List of Acronyms

ADRC=Aging and Disability Resource Center
CLOG=Case Log
CMS=Centers for Medicare and Medicaid Services
CSM=Community Supports Management System
DEA=Department of Elderly Affairs
DHS=Department of Human Services
DME=Durable Medical Equipment
HCBS=Home and Community Based Services
LOC=Level of Care
LTC=Long Term Care
MA=Medical Assistance (Medicaid)
MMIS=Medicaid Management Information System
MOW=Meals on Wheels
MFP=Money Follows the Person
NH=Nursing Home
NHTP=Nursing Home Transition Program
OCP=Office of Community Programs
PACE=Program for All-Inclusive Care for the Elderly
PCP=Primary Care Physician
PERS=Personal Emergency Response System
QoL=Quality of Life
RN=Nurse
RTH=Rhode to Home
SW=Social Worker
TC=Transition Coordinator

1. Introduction to NHTP/RTH

The Office of Community Programs under the Rhode Island Executive Office of Health and Human Services, provides two programs for transitioning Medicaid eligible nursing home residents to the community. The Nursing Home Transition Program (NHTP) has been in place since 2000 and over 200 individuals have been successfully transitioned to community living. During the first year of operation from November 2011- 2012, the Money Follows the Person demonstration program (MFP) under the name Rhode to Home (RTH) has transitioned over 40 individuals. The purpose of these programs is to allow Rhode Island residents, who have been living in an institution, to experience more independence and a better quality of life by returning to the community with the appropriate supports. Both the NHTP and RTH programs are designed as person-centered programs, where the individual and his/her family/guardian are involved in all stages of the assessment, plan development and care delivery process.

As part of the state's effort to rebalance the Long Term Care system and to enable Medicaid eligible individuals the opportunity to receive the most appropriate services in the most appropriate and least restrictive setting, the NHTP Program was developed as a contract for an 18 month project. The project began in 2009 with the goal of transitioning 80 individuals from a nursing facility to a home and community based setting. At the end of the contract period, the Office of Community Programs began administering the program. The Staff consists of 4 nurses and 2 social workers. The nurses and social workers work as a team to assess the individual, assist with securing housing, assist in transitioning the individual to the community by arranging all necessary services, and provide short-term case management. To date, the case management has been for approximately 30 days, except in cases where the case is medically complex. The length of time an individual receives case management may be extended in the future. Individuals in the RTH program receive the same assessment and transition assistance, but the length of their case management is a full 365 days. In addition, they receive a 24-hour emergency backup provider to fill in whenever any needed services or supports fail. The RTH staff consists of one Transition Coordinator, one nurse, a part-time Housing Specialist and a Referral Coordinator.

The RTH program is a 5-year federal rebalancing demonstration grant under the Affordable Care Act (ACA). Rhode Island was awarded this grant in 2011 and began transitioning nursing home residents in the fall of 2011. The primary goal of this demonstration grant is to provide assistance to states to balance their long-term care systems; eliminate barriers and mechanisms in State law, State Medicaid plans, or State budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice; strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS. The Federal government provides enhanced federal match on the expenditures for both home and community based services provided and administrative costs. The enhanced federal match is used to further rebalance LTC services by reinvesting into community LTC

services and supports.

2. Determining NHTP and RTH eligibility

Although many nursing home residents may be appropriate for transition to the community, they will not all be eligible under the NHTP or RTH programs. CMS has developed certain criteria to determine if a nursing home resident is appropriate for transition under RTH. The following three criteria must be met:

1. individual must be a Medicaid beneficiary,
2. individual must be in a qualified institutional inpatient facility for a period of at least 90 consecutive days, and
3. individual must move to a qualified community residence.

For transitions under NHTP, only the first criteria need be met.

1. Individual must be a Medicaid beneficiary.

The process regarding eligibility for Long Term Care Medical Assistance (LTC MA) through Medicaid will be outlined in Section 8 of this manual.

To be appropriate for RTH, an individual must already have LTC MA eligibility. An individual needs to have LTC MA eligibility for at least one day to qualify for RTH. This means that if a person is awaiting a decision on their Medicaid eligibility, they are eligible to transition as soon as they have one full day of MA eligibility. Some individuals may choose to leave the Nursing Home prior to their LTC MA-eligibility. In these cases the individual would be returning to the community with skilled services, if determined necessary, however there would be no HCBS. The individual may continue their application for HCBS with the designated Long Term Care Field Office.

2. Individual must be in a qualified institutional inpatient facility for a period of at least 90 consecutive days.

Upon referral to the Office of Community Programs (OCP), an RTH Screening Form is completed by the Referral Coordinator. This form prompts the Referral Coordinator to verify the information provided by the referring Nursing Home on the OCP Referral Form. It contains a decision tree with elements regarding the length and nature of the nursing home stay. An individual must have 90 consecutive days of skilled nursing at a Nursing Home.

Stays for the primary purpose of short-term rehab, and paid for under Medicare, do not qualify for RTH. In some cases, an individual's initial reason for admission will be short-term rehab, but for other reasons, their Nursing Home stay will extend to 90 days or beyond 90 days. If the Nursing Home admission was for short-term rehab and the Nursing Home stay was extended for other reasons, there must be 90 days after the end of short-term rehab for the individual to qualify for RTH.

3. Individual must move to a qualified community residence.

When they are referred to the OCP Nursing Home Transition Program, some individuals already have housing available to them and others do not. Some individuals will be interested in moving back to their former house or apartment, or may have plans to move in with a family member. Other individuals may have lost the housing they had prior to being admitted to the Nursing Home, or may not safely be able to return to their prior housing situation. Whether an individual already has housing available or needs assistance with obtaining housing, all housing must meet certain criteria outlined by CMS in order to be considered a qualified community residence under RTH.

A Qualified Residence must meet the following requirements:

- Home owned or leased by individual or the individual's family individual or
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas which the individual or the individual's family representative has domain and control and include the following provisions:
 - The dwelling must have a lease that is considered a legal document by all parties signing or referenced in the lease. The lease may be signed by someone other than the individual or the individual's family representative.
 - The lease must not name anyone other than the RTH individual or a family representative as having domain and control over living, sleeping, bathing, and cooking areas of the dwelling.
 - The building must give access to the community. For example, in order to assure security, safety or privacy, many apartment complexes have gates, multiple doors, or security guard checkpoints leading to an exit on the street outside of the complex. Each tenant or their family representative must be provided a key, identification card, or keypunch number to easily get in or out of a complex or facility 24 hours a day.
 - The apartment in which the RTH individual resides must comport with federal fair housing guidelines.
 - To be a qualified residence under RTH, leases should not:
 - Include rules and/or regulations from a service agency *as conditions of tenancy* or include a requirement to receive services from a specific company;
 - Require notification of periods of absence, e.g. a person who is absent from a facility for more than 15 consecutive days, or discuss transfer to a nursing facility or hospital;
 - Include provisions for being admitted, discharged, or transferred out of or into a facility; or
 - Reserve the right to assign apartments and change apartment assignments, or,
- A residence, in a community residential setting, in which no more than four unrelated individuals reside.

3. Referral Process and Team Assignment

When a Nursing Home Transition referral first comes in to the OCP, a Screening Form is completed to direct the referral to the appropriate team—NHTP or RTH. It is not always clear initially if the individual will be RTH eligible, but the screening form addresses such questions as the length of stay in the nursing home, the nature of the nursing home stay and Medicaid eligibility.

Based on the outcome of the RTH Screening Form, the referral will be assigned to either the NHTP team or the RTH team. Each referral will be assigned to a pair of clinical staff, consisting of a social worker and a nurse. The Referral Coordinator will prepare each file based on the outcome of the Screening Form, and will provide all applicable documents that the team will need to work the case. The Referral Coordinator will also print out certain screens from InRhodes, as applicable, and information relating to any involvement with protective services will be included. Each file will include a Case File Checklist, which is the place to record the dates that forms were completed and submitted.

The OCP/RTH nurse will meet with the individual in the Nursing Home and will explore with the individual the following topics:

- **Nursing Home Stay** including the reasons why they were admitted, where they were living before, how the decision was made to move into the Nursing Home, who made the decisions and why this particular Nursing Home was selected.
- **Services and Benefits**- supports or services provided by provider agencies, family and friends prior to Nursing Home admission, likes and dislikes about the Nursing Home, and what social and recreational activities they enjoy or have participated in, and their interest in moving out of the Nursing Home.
- **Potential Individual's Vision of Community Residences** such as where they would live, prior experience working with care givers and personal care/home health providers, needed assistance for transition, their major concerns or fears about transition into the community, real or perceived barriers to living in the community.
- **Issues Related to Successful Transition** including eligibility for Medicaid/RTH, available and affordable housing, existing financial resources and their ability to manage them, legal or criminal issues, ability to access primary and specialty medical care, existing support system, medical and behavioral health conditions, consumer awareness and skills, consumer connection to the community, factors that may endanger the health and safety of the consumer and engaging guardians, when assigned.

FORMS: OCP Referral Form, RTH Screening Form, Protective Services History Form, Case File Checklist

4. ADRC/Options Counseling

5. Assessments and Care Planning

Assessments

Because not every individual who will transition is Medicaid eligible at the time of OCP referral, and because, in some cases, the OCP referral comes in only days before an individual is due to be discharged, the OCP/RTH nurse and the Transition Coordinator (TC)/Social Worker (SW) will need to prioritize their caseload. Priority should be given to those individuals who are due to be transitioned right away and those individuals who already Medicaid eligible. Those without Medicaid eligibility will normally be lower on the list for scheduling an assessment; however, if the clinical staff are going to be at a particular nursing home (NH) to meet with other individuals, it would be a good idea for the OCP/RTH nurse to complete an assessment on a person whose Medicaid eligibility is pending. That way, once their Medicaid comes through, the individual's assessment will already be complete and the NHTP/RTH staff's time will be used most efficiently.

Once the individual has been determined to be Medicaid eligible (or based on prioritization of caseload) the OCP/RTH Nurse will then conduct a comprehensive assessment that will consist of the following components: (As explained above, the assessment may take place prior to MA eligibility.)

- **Comprehensive Transition Assessment (CTA)** This assessment includes the following elements as well as some not listed here: referral source, individual identifying data, informal support systems, residence and living arrangements, home based services receiving, functional abilities/ADL assessment, behavioral health assessment, fall risk, hearing and vision assessment, diet, dental problems, height/weight, health care providers, medical issues, skin integrity, pain, diabetes, labs and immunizations received, transition recommendations including HCBS and medical equipment needs.
- **Risk Assessment** This includes: health and medical conditions, caregiver and support needs, financial situation, legal issues, availability of housing, linkages with medical and health care providers, identification with transitioning into the community and other factors that may adversely affect the welfare and safety of the individual.

Based on these assessments, a multidisciplinary team, consisting of the OCP/RTH nurse, the individual, family/guardian, nursing home clinical staff, the individual's primary care provider and other medical specialists involved with this individual, will determine whether or not the individual is appropriate for transition.

The OCP/RTH Nurse will then complete the Post-Assessment Status Form. This form captures whether or not the individual is appropriate to transition or not appropriate to transition, or if a decision regarding transitioning has not yet been made. If the OCP/RTH Nurse determines that the individual is appropriate for transition, they should indicate on this form whether or not the individual has housing or will need assistance finding housing, as well as any relevant information. If the individual is not a candidate, the reason should be selected and if a decision has not yet been made regarding transition, the OCP/RTH Nurse should provide detailed comments.

This form also serves as the record for the date the individual signed the RTH Informed Consent or the date they declined participation, as well if there were any issues obtaining informed consent.

Please see section 5 for information regarding the RTH informed consent process.

Each individual who has been assessed and made the choice to transition to the community must sign the Notification of Recipient Choice (CP-12) form which indicates the individual is aware they have a choice to remain in the nursing facility or return to the community to receive an array of home and community based services.

The OCP/RTH Nurse also should have the individual sign the Authorization to Obtain or Release Confidential Information (Agency Release) and the Authorization for Disclosure/Use of Health Information (Medical Release). These forms will stay in the individual's case record, unless requested by a provider.

FORMS: CTA, CMA, Rhode to Home Care Plan Part 3. Risk and Mitigation Plan, Notification of Recipient Choice (CP-12), Authorization for Disclosure/Use of Health Information (Medical Release), Authorization to Obtain or Release Confidential Information (Agency Release), Post-Assessment Status Form

Care Planning

The multidisciplinary team, as defined above, will develop a comprehensive person-centered care plan that will be based on individual preference and recommendations that were made from the comprehensive assessment.

For NHTP individuals, The Global Waiver Service Plan (GW-SP) is completed. The service plan must be signed by the individual/guardian/representative and a copy must be given to the individual. The GW-SP will be entered into the Community Supports Management System (CSM).

For Rhode to Home individuals, there is a 3-part Rhode to Home Care Plan which must be completed. It is made up of three sections:

1. **Service Plan** This form outlines the goals, frequency and duration of services, primary care plans, residential modifications, formal and informal supports required, recreational and cultural activities, and responsibility for referrals and linkages. Because the RTH service plan incorporates the same elements used on the GW-SP, the RTH service plan will be entered into the CSM by the Referral Coordinator
2. **Risk and Mitigation Plan** Based on the risk assessment, a mitigation plan will be developed to prevent or mitigate those identified risks.
3. **Emergency Back-Up Plan**- An individualized emergency back-up plan is developed to provide back up for those services and supports that if not otherwise provided could put the individual's safety, health or well-being at risk. Each 24-hour Emergency Backup Plan will outline 3 levels of backup: 1. the individual's own personal backup (family or friends), 2. the agency providing the HCBS and 3. the Alliance for Better Long Term Care, which has been

contracted to provide emergency backup to all RTH individuals. These three layers may change based on the need of the individual. For example if the individual receives CNA services, the first level of back up may not be the individuals own back up of friends/family, the individual or their representative may want a backup agency to be the first level; however the friend/family may be appropriate as the first level of back up coverage for transportation coverage. Each service or support back up coverage is individualized, and if a family or friend is used as a level of back up, they must agree and able to provide such service.

The individual or their representative will be required to sign their Care Plan, along with the OCP/RTH nurse. As part of the care plan development process, for both NHTP and RTH, the individual is informed of their right to appeal decisions regarding the provision of care.

At this point in the process, the RTH Hotline number should be given to the individual and/or their representative. The RTH Hotline has been established as a dedicated phone line for any questions or complaints related to the RTH Program. This hotline is staffed during normal working hours and has a voicemail for calls received after working hours. This hotline is also used as the central point for RTH individuals to contact their Transition Coordinator, or, if their Transition Coordinator is not available, another RTH staff person can provide the caller with immediate assistance.

FORMS: DHS-Individual Plan of Care, RTH Care Plan (1. Service Plan, 2. Risk and Mitigation Plan, 3. Emergency Backup Plan) , Authorization for Disclosure/use of Health Information for the Alliance

6. Informed Consent Process

Once the individual has meet the 90 day nursing home stay requirement and is LTC Medicaid eligible, the RTH nurse will educate the individual and his/her family/guardian about the RTH program, including: its purpose, voluntary nature, impact on the individual's Medicaid eligibility and the difference between provider and self-managed services. Other topics to be covered include:

- benefits of participating in the program,
- information about services available to the individual at the conclusion of the demonstration year,
- responsibilities of the individual while enrolled in the program,
- confidentiality of RTH individual information,
- the individual's ability to withdraw from the program at any time,
- specific contact information for reporting incidents of abuse, neglect, theft or financial exploitation,
- specific contact information for reporting complaints or appealing decisions regarding the delivery of services,
- specific contact information for complex questions regarding benefits or services,
- the option to formally decline participation in the program, and

- the possibility that the individual may have to make a monthly contribution toward the cost of services.

The RTH Nurse will answer all of the individual's questions and will discuss the program with the individual and his/her family/guardian to ensure that they have sufficient information to make an informed decision about participating.

Once the RTH Informed Consent Form has been thoroughly reviewed and discussed and all questions have been answered, both the individual/family/guardian and the RTH Nurse will sign and date the form. Signing the form serves as acknowledgement that the individual/family/guardian fully understands the program and agrees to participate. Each case record will include two copies of the form—both should be signed by the individual and both should also be signed by the RTH Staff. One copy should be left with the individual, and one should go into the case record.

After the Informed Consent has been signed, please indicate the date it was signed on the Post-Assessment Status Form. This date will be entered into the Access database and will flag someone as RTH for all reporting and tracking.

FORMS: Informed Consent Form, Post-Assessment Status Form

7. Quality of Life Survey

A component of the RTH program is the Quality of Life Survey. This survey is part of a quality initiative to evaluate MFP nationally. The survey measures the quality of life of participating individuals before and after their transition to the community. It measures quality of life in seven domains: living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction and health status. The survey is administered to RTH individuals just prior to transition, 11 months after transition and again 24 months after transition. It takes approximately 15-20 minutes to complete. The survey is administered in person and in a private setting.

The Quality of Life Survey is administered by a designated staff. Once a person has agreed to participate in RTH, the RTH Nurse should ask the individual if they are willing or refuse to participate in the survey and their response must be indicated. Next, they will complete and submit to the designated staff, the Quality of Life Referral Form. This form provides the designated staff with some basic information so that he/she may contact the individual once the transition date has been determined. The RTH Nurse should keep the designated staff updated on the potential transition date, as she will need to attempt to administer the Quality of Life Survey approximately two weeks prior to the transition date.

If the individual refuses to participate in the survey, the designated staff still requires the Quality of Life Referral Form, as he/she will make one additional attempt to invite the individual to participate.

For the 11 and 24 month follow up surveys, the designated staff will contact the individual directly to schedule the interview. The designated staff will submit a QoL Survey Tracking Form for every interview that is attempted or completed.

FORMS: QOL Referral Form, QoL Survey Tracking Form

8. Medical Assistance (Medicaid) Eligibility and Level of Care

In order to be eligible to reside in a Nursing Home or receive Home and Community Based services an individual must apply for and be eligible for Long Term Care Medicaid. Eligibility consists of financial eligibility which is determined by DHS Long Term Care Field Offices and clinical eligibility (Level of Care) which is determined by the EOHHS Office of Medical Review. (For those individuals who already have community Medical Assistance, the application process may be less time consuming, nonetheless, a formal application must be sent to the appropriate Long Term Care Field Office and a Level of Care must be completed).

Prior to transition to the community, the individual must be eligible for LTC Medical Assistance in order to qualify for Home and Community Based Services. In most cases, the nursing home or the family have started this process. It is important for the TC/SW to work with the LTC field office and Office of Medical Review to complete this process.

It is always in the best interest of the individual to wait in the nursing home until the approval of the Medicaid in order for the individual to receive HCBS upon discharge. However, if the individual chooses not to wait in the Nursing Home, they may return home with other services (short-term skilled) that they may be eligible for, while they continue to wait for the Medical Assistance Approval.

Should the individual return home without MA approval, The LTC Field Office will need to be informed so that they are aware the individual may still want services at home and the application must go forward. In this instance, the TC/SW must inform the individual of the contact person in the LTC field office in order for them to complete the process of receiving services.

Should the individual not be eligible for LTC Medicaid, they will not be eligible to receive Home and Community Based Services via the Global Waiver. The nursing home will be responsible for exploring other options for the individual.

For those individuals who have applied for LTC Medicaid but are not yet Medicaid eligible when they are referred to the NHTP/RTH programs, the Data Entry Clerk will regularly check eligibility status in InRhodes, and will inform the TC/SW when the MA eligibility has been approved. If the individual has applied for LTC MA, and after 2-3 weeks they are still not listed as eligible through InRhodes, the TC/SW should contact the LTC worker to see if any information is missing from the application and if any additional documentation is needed.

A Medicaid Level of Care (LOC) needs to be done annually on every LTC Medicaid recipient. If an individual who resides in a nursing home is transitioning to the community and the current level of care is over 12 months old, the TC/SW should work with the nursing home to complete a provider medical statement (PM-1). The PM-1, along with the CTA or the CMA, should be submitted to the Office of Medical Review (OMR) nurses for review.

If an individual has successfully transitioned into the community and the level of care is up for recertification, the TC/SW should work with the individual's primary care physician to obtain the Provider Medical Statement (PM-1). The PM-1 and the CMA should be given to the OMR nurses for LOC review.

If at any point the individual is referred to the Shared Living program, a new LOC is needed as well as a new CMA. The same process as described above, regarding obtaining the medical provider statement, would apply.

Forms: Provider Medical Statement (PM-1)

9. Finding Housing

If the individual needs assistance finding appropriate housing, the OCP/RTH nurse will complete a Housing Preferences and Referral Form which identifies the individual's preferences for geographic location, preferred housing type (assisted living, public housing, etc.) and other information needed to assist with obtaining housing. The OCP/RTH nurse will give the Housing Preferences and Referral Form to the Housing Specialist along with the individual's case record. The Housing Specialist will then work on securing housing and will assist the individual with the housing application process. The Housing Specialist will provide monthly updates regarding her progress towards securing housing. Once housing is found, the Housing Specialist will transfer the case record to the TC/SW to complete the transition process. If at any point the Housing Specialist becomes aware of a change the individual's medical status, the Housing Specialist will communicate with either the assigned OCP/RTH nurse or the TC/SW, who will then review the feasibility of continuing to pursue community transition.

FORMS: Housing Preferences and Referral Form, Housing Progress Update

10. Delay in Transition/Arranging for Services/Transition Process /Referral to Other State Agencies for Case Management

Delay in Transition

For those individuals who experience a delay in transitioning due to some reason other than housing, the Transition Coordinator/Social Worker or the OCP/RTH Nurse must complete a Nursing Home Transition Pending Progress Update Form. This form is the place to record anything causing a delay in transition and any progress towards transitioning the individual. This form should be completed within 30 days of the initial assessment, and then at least monthly thereafter.

FORMS: Nursing Home Transition Pending Progress Update Form

Arranging for Services

Once the assessment is complete, the OCP/RTH nurse will complete the service calculator tool which will determine the amount of hours to authorize for home care services or they will recommend Assisted

Living services. The nurse will also identify any other services the individual will need to remain safely in the community.

The designated TC/SW will arrange for the services and supports identified by the OCP/RTH nurse in the Care Plan which may include home health aide services, meals on wheels, PERS. The only services and supports that will not be arranged for by the Transition Coordinator/Social Worker will be for any needed medical services. The nurse will work with the NH staff to arrange for those needed medical services through agencies in the community prior to transition.

FORMS: Service Calculator Tool, Nursing Home Transition Pending Progress Update

Transition Process

The TC/SW will work with the Nursing Home to prepare for discharge. The TC/SC, prior to transition, will conduct a readiness home review to assess the housing situation to ensure it continues to meet the criteria to be eligible for RTH (if at any point the individual chooses a non-qualified housing, the individual will continue the transition process, but will disenroll from RTH and transition through the NHTP), and to ensure the home continues to meet all safety requirements. The TC/SW in collaboration with the OCP/RTH Nurse will also ensure that all services and supports are in place prior to transition, to ensure there is no delay in their start.

In preparing the individual for transition, the TC/SW will review the Critical Incident Fact sheet and the 24-hour Emergency Back-up Plan and fact sheet (for RTH individuals) with the individual to ensure they or their caregiver know how to recognize abuse, neglect and exploitation and how and when to report all critical incidents and to ensure they know how to activate their back up plan and that all levels of back up are still appropriate. Upon discharge the individual will receive a copy of both fact sheets and for RTH, a copy of their signed Emergency Backup Plan with emergency contact numbers to keep with them at home as a reference. The Transition Coordinator/Social Worker will also encourage the individual to place themselves on the Rhode Island Special Needs Emergency Registry. This information is shared with state and local responders such as police and fire departments.

At the time the individual transitions from the Nursing Home, the TC/SW will complete a Transition Placement Form indicating the date of transition, the transition placement, type of housing and other demographic information.

FORMS: Qualified Residence and Home Safety Evaluation, 24-Hour Emergency Backup Plan Fact Sheet, Critical Incident Fact Sheet, Emergency Back-up Plan, Transition Placement Form

Referral to Other State Agencies for Case Management

The TC/SW will also notify the state case management agency that will take over the case at the expiration of the 365 RTH days, or upon conclusion of their participation in NHTP. Cases will be referred, through the referral form, either to the Department of Elderly Affairs and their associated case management agencies, or the appropriate Long Term Care office. The Long Term Care office will also

receive a referral for individuals who will receive their case management through DEA, in order to update the MMIS system.

Initially, at the time of transition, the Transition Coordinator will fax a Nursing Home Transition Case Management Cover Sheet to DEA and/or LTC for RTH individuals. Thirty days prior to the transfer of Case Management, the more detailed Nursing Home Transition Referral form, with all applicable forms, should be faxed to LTC or DEA. For individuals transitioning through NHTP, the Social Worker will fax the appropriate referral form at the time of transition, which is to include all applicable forms.

Division of Elderly Affairs (DEA) Case Management

A referral to DEA case management should be made for: 1) individuals of any age transitioning to assisted living, or 2) individuals who live in the community, who are 65 years or older and have protective service issues, have been serviced by DEA in the past or who may need more intensive case management.

For these individuals, the TC/SW, will:

- ensure the individual is approved and eligible for LTC Medicaid prior to transition to ALR or community setting,
- ensure that SSI Enhanced paperwork is completed by the Nursing Home and submitted to Diane Taft, for those individuals who are eligible, and who are transitioning to an Assisted Living,
- work with LTC office to ensure the proper Waiver Code (L- DEA AL; F- RIH AL; D-DEA community) is entered into InRhodes,
- send a referral form and all required documentation, to the appropriate LTC Field office indicating the program needed as well as indication that case management will be provided by DEA,
- send Case Management Referral form, for NHTP individuals and all needed documents to DEA Case management Supervisor on the day of discharge. The day of discharge will be the Waiver Start Date.
- send only the coversheet to DEA which will include the waiver start date (NH discharge date), the DEA case management start date (which will be approximately 365 from discharge date), the individual's income and other demographic information for RTH individuals only.
- For assisted living individuals, DEA will then complete the Individual Notification Form and the facility notification in order for DEA to enter the individual share into MMIS.

LTC

For individuals under 65, and/or for individuals over 65 who may not have protective service issues or who do not need more intensive case management services provided by DEA, the TC/SW will:

- ensure that the individual is approved and eligible for LTC Medicaid prior to transition to a community setting, and
- send a referral form and all required documentation to the appropriate LTC Field office indicating the program needed as well as the start date of services.
- For RTH individuals, the Transition Coordinator/Social Worker will indicate to the LTC worker when case management services will begin with LTC (365 days).

FORMS: Nursing Home Transition Case Management Cover Sheet, Nursing Home Transition Referral Division of Elder Affairs, Nursing Home Transition Referral Long Term Care

11. Monthly Contact

Once the individual has transitioned to the community, the TC/SW will become the primary contact and care manager for the individual, to ensure a successful community placement. The OCP/RTH nurse may also continue to be involved in case management, should the individual's medical needs require nursing oversight.

For those individuals who transition via NHTP, the Social Worker or OCP nurse will manage the entire case for a minimum of 30 days. Should the case require extended involvement, the NHTP team will keep the case longer and will notify DEA or LTC via Referral Form of the case transfer date.

Please see further instructions in Section 14.

The role of the TC, for individuals in RTH, will be to provide case management services for the 365 days the individual is enrolled in the RTH program. The TC will also assist the individual in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. The TC is also responsible for the ongoing monitoring of the provision of services included in the individual's plan of care. The care plan will be revised to meet changes in the individuals needs at any time throughout their 365 days of participation.

Within 24 hours of a transition, for both NHTP and RTH, the TC/SW is expected to contact the individual and then to perform a follow-up visit with the individual within 10 days of transition.

To ensure that the initial phase of the transition is proceeding as planned, and to determine if any changes need to be made to the care plan or if additional service/supports are required, the TC/SW will contact the individual (either by phone or in person) weekly for the first month. These weekly visits or contacts should include:

- (RTH) discussion around the proper use of the 24-hour back up system,
- (NHTP/RTH) discussion around the identification and reporting of critical incidents related to abuse, neglect and exploitation,
- (NHTP/RTH) service or care issues that are not being met,
- (NHTP) a visit must take place during the last week of case management to discuss the transition to a new case management entity.

For RTH individuals, monthly visits will occur for the first 3 months, after the first 3 months the Transition Coordinator will make monthly phone calls and visit at a minimum quarterly. However the frequency of contact will vary depending upon the needs of the individual.

As part of ongoing monitoring, the TC/SW will, at a minimum, discuss with the individual during the monthly contact the following: (Please note: for NHTP individuals where the TC/SW assumes case management for longer than 30 days, the following do apply)

- review any critical incidents that may have occurred (if there is a newly discovered critical incident, a Critical Incident Report Form would need to be completed and submitted to the RTH office, *please see section 12 for further instruction*),
- update on any health or medications changes,
- (RTH only) revise progress towards goals identified on the service plan, address any barriers to attaining those goals,
- (RTH only) review 24 hour back up plan and update as needed,
- (RTH only) review risk assessment and ensure it address all current needs,
- (RTH only) review mitigation plan and ensure plan is currently working and revise as needed,
- review individual's satisfaction with providers, ensuring that all essential supports are operating reliably and effectively,
- review individual's adaptation to community living, which includes the individual's social and community options,
- review formal and informal supports and ensure individual is receiving adequate services and/or supports,
- review any new problems or difficulties and help the individual improve their strategies to resolve the problem(s),
- review current housing situation and whether it currently is appropriate and meeting the needs of the individual,
- review durable medical equipment, confirm that it is still be used and still working appropriately,
- review the individual's nutritional needs, food supply etc., functional status both physical and mental, and individual's ability to self-manage in the community,
- review previous and upcoming doctors' appointments,
- if caregiver involved, discuss with caregiver their responsibilities, stress etc.
- review of any other needs or concerns applicable to each individual

RTH individuals may disenroll from the program at any time, *please refer to section 15 for further information and instructions.*

FORMS: NHTP/RTH Home Visit Progress Notes, Critical Incident Form, Disenrollment Form, Disenrollment Notification Form

12. Critical Incidents- RTH/NHTP

For RTH individuals, The Alliance for Better Long Term Care is the first point of contact for reporting critical incidents. The Alliance's responsibilities are as follows: upon receipt of a report, the Alliance will 1) triage the situation to ensure the individual is safe, 2) complete a Critical Incident Report Form (External), 3) call the assigned TC within 24 hours of learning of the incident, and 4) fax the report to the TC within 48 hours. Upon receipt of the Critical Incident Report Form from the Alliance, the TC will contact the individual to review the incident with them. The TC will adjust the Care Plan if necessary, and will put in place measures to prevent similar incidents from occurring in the future. For those critical incidents that result in a hospitalization or Nursing Home readmission, *please see section 13 for information regarding completing a Suspension/Reactivation Form.*

If an individual has a break down in their 24 hour back plan, the Alliance. For RTH individuals, serves as the 3rd level should of back-up. Prior to transition, the RTH individual and/or care giver and the TC review the 24 hour back up plan, ensuring it is still appropriate, and discussion around when the Alliance should or should not be called. In those incidences when the Alliance is called the Alliance will then triage the situation to determine the severity of the situation. If the situation requires back up the Alliance will arrange or provide for the necessary service or support. The Alliance will then phone the assigned TC within 24 hours and fax to the TC within 48 hours a 24-hour Backup Usage Report. This report will indicate the nature of the call, the assistance that was provided by the Alliance and description of why the first two layers failed. Monthly, the RTH Deputy Director will receive an Alliance Emergency Back-up Activity Report, detailing all the calls received for RTH individuals, regardless if emergency back was provided or not. This monthly report will be shared with each the TC. When the TC received a 24-hour back up usage report or the monthly activity report, the TC must contact the individual, review the 24 hour back up and revise as needed to ensure it still meets the needs of the individual

For NHTP individuals critical Incidents will be reported directly to the Social Worker. In some cases, the Transition Coordinator/Social Worker, for both RTH and NHTP, will not learn of the critical incident until he/she is performing a monthly visit or call. If this is the case, the Transition Coordinator/Social Worker must complete and submit a Critical Incident Report Form (Internal), review the incident the with the individual, adjust the Care Plan if necessary, and put in place measures to prevent similar incidents from occurring in the future.

In addition, if the Transition Coordinator/Social Worker or the OCP/RTH Nurse learns of any abuse, neglect, self-neglect or exploitation of an individual, they should complete and submit the DEA Protective Services Referral Form.

FORMS: Critical Incident Form (External), Critical Incident Form (Internal), Suspension/Reactivation Form, 24-hour Emergency Backup Usage Report, Alliance Emergency Back-up Activity Report, DEA Protective Services Referral Form

13. Suspension/Reactivation

Individuals in RTH are eligible to participate in the program for 365 days. The start date of services is the day of discharge from the nursing home/transition to the community. For those with no disruptions in their time in the community, their end date will be 365 days after the date of their transition. For many individuals though, there will be one or more hospitalizations or nursing home readmissions during the year. These re-institutionalizations will cause a break in the 365 continuous days. In addition, some individuals may leave qualified housing, may not follow their treatment plan, or may enroll in the PACE program after transitioning to the community. These events would also trigger a suspension.

The Suspension/Reactivation Form is the place to capture these breaks in community placement. This form captures the date of the suspension and the suspension reason, as well as the reactivation date.

The **suspension effective date** is the date the individual was admitted to a hospital, nursing home or psychiatric facility or the date the Transition Coordinator became aware that the individual left qualified housing, stopped following their treatment plan or enrolled in PACE. You will need to select one of following **reasons for suspension**:

- Hospitalization
- Re-admittance to a nursing home or psychiatric facility
- Left qualified housing
- Individual is not following their treatment plan
- Individual enrolled in PACE

If the reason for suspension was re-admittance to a nursing home or psychiatric facility, you will also need to select the **reason for admission** from the following list:

- Acute care hospitalization followed by long term rehab
- Deterioration in cognitive functioning
- Deterioration in health
- Deterioration in mental health
- Loss of housing
- Loss of personal caregiver
- By request of individual or guardian
- Lack of sufficient community services

The **reactivation effective date** is the date the individual returns to the community.

Please note: If the re-institutionalization is for longer than 30 days (31 or more days), a new plan of care is required.

If you are suspending an individual for a reason other than re-institutionalization, you will also need to complete and have the individual sign the MFP Demonstration Program Suspension Form. This form notifies the individual in writing that they are being suspended from participation in RTH, and the reason(s) why. This form informs the individual that they may be re-activated at a future date if the

conditions surrounding the reason for suspension change. It also indicates that if circumstances do not change within a period of 6 months, that the individual will be permanently disenrolled from the program.

FORMS: Suspension/Reactivation Form, MFP Demonstration Program Suspension Form

14. Transfer to Other State Case Management Agencies

At least 30 days prior to the expiration of the 365 participation days for RTH individuals, the TC/SW will begin discussions with the individual about transitioning case management to other state agencies. The TC/SW will contact the appropriate state agency and begin the process to ensure there is a seamless transition at the end of the 365 days. For DEA the Transition Coordinator will send to the DEA CM agency the referral form with all required documentation.

The TC and the new DEA Case Manager will meet with the individual and collaboratively put together a transition plan that will take place after day 365. For individuals who will transition into the LTC case management system the individual will receive the appropriate contact information for the LTC field office and the supervisor name, in case the individual has questions before an official case manager is assigned.

If the individual receives home care services, the TC/SW should inform the home care provider that the individual's participation in the RTH is ending this month and that the provider should not span date bill for this month, to ensure that claims will not be denied.

For NHTP individuals, the transfer to case management process should begin soon after their transition to the community.

FORMS: Case Management Referral Form and Case Closeout Form

15. Disenrollment

Individuals are allowed to withdraw from the RTH program at any time, for any reason. In addition, there are circumstances under which an individual may be disenrolled from RTH by the TC/SW

When a person is disenrolled, the TC/SW should complete and submit the RTH Disenrollment/Unable to Transition form, which includes the date of disenrollment and the disenrollment reason.

The reasons for disenrollment are death; individual no longer needed services, voluntary withdrawal, unable to transition and other. In addition to the RTH Disenrollment/Unable to Transition form, the TC/SW will have the individual sign a Disenrollment Notification form. This form explains to the individual the reason they will no longer be enrolled in RTH.

FORMS: Disenrollment Notification Form

16. CLOGing in InRhodes

In addition to submitting the paper forms at every step in the transition process and throughout the case management period, NHTP and RTH staff should be CLOGing important information in the InRhodes system. CLOG stands for Case Log and refers to any case note you enter into InRhodes. The Data Entry Clerk will be responsible for CLOGing events such as the date the referral was received and the date the individual becomes LTC MA eligible. The OCP/RTH Nurse and the Transition Coordinator/Social Worker are responsible for CLOGing other important events such as the date the assessment was completed, the date the individual transitions, the date of any hospitalizations or critical incidents and any status change. This information will be helpful for all team members to see and is necessary for the LTC or DEA case worker when they receive the case.

17. Timeline for Submitting Forms

Under the RTH demonstration grant, we are required to report to CMS periodically on a number of program elements. In addition, we have weekly reporting we must provide to HP, the state's fiscal intermediary to keep RTH claims accurate and up-to-date. Because of these reporting requirements, we need to have the data in our Access database updated weekly. In order for the Access database to be kept up-to-date, we need all clinical staff to submit forms in a timely manner. The Informed Consent Cover Sheet, Transition Placement Form and Suspension/Reactivation Form should be submitted as soon as possible after the event (consent, transition, suspension) takes place, but at least within one week from the time of the event. Please note: most forms require a signature and date.

18. Detailed Review of Forms

OCP Referral Form

Completed By	Nursing Home Social Worker
Program	NHTP and RTH
Signed by Individual	NO

This form is completed by the Nursing Home social worker and faxed to the OCP. The Referral Coordinator reviews the form and follows up with the Nursing Home if any information is missing. She confirms the length of the Nursing Home stay and completes the RTH Screening Form. The Referral Form goes into a new case record, which is distributed to the OCP/RTH Nurse. This form is required for both NHTP and RTH individuals.



Nursing Home Transition
Referral Form

Phone: 462-6393

Fax: 462-4266

Is this referral in response to Sec Q? Yes No

Today's Date: _____ Anticipated D/C date: _____ NH D/C Planner Name: _____

Name of Nursing Home: _____ Phone: _____

Client Name: _____ DOB: _____ SSN: _____

Address: _____ Apt#: _____ Floor: _____

City/Town: _____ Zip: _____ Telephone Number: _____

Primary Language: _____ Interpreter Needed Yes No

Spouse Name: _____

Primary Contact: _____ Relationship _____ Contact Phone _____

Address: _____ City/Town _____ State _____ Zip _____

Has the client experienced chronic homelessness? Yes No

Is the client a veteran? Yes No

Diagnosis: _____ BIMS Score: _____

Admission Date: _____ Reason for Admission: _____

If the sole reason for admission was for short-term rehab, what is/was the last Medicare covered day for short-term rehab? Date: _____

Admitted from: Hospital Assisted Living Home Rehab Facility Other _____

Recent Hospitalizations: Yes No. If yes, provide name of Hospital: _____

Reason for Hospitalization: _____

Name of Health Insurer: _____ Secondary Insurer: _____

Is the primary payer PACE (program of all inclusive care for the elderly)? Yes No

1. Does the client have LongTerm Care Medicaid? Yes No

If not:

Has client applied for Long Term Care Medical Assistance (MA)? Yes No.

If yes, when was application submitted? _____

Where was the application submitted? _____

If no, is the family or Social Worker aware of the need to submit the application? Yes No

Please explain: _____

Is client anticipating applying for MA in the future? Yes No

2. What are client's care planning needs once discharged?

Skilled Nursing PT/OT DME

CNA/Homemaking Lifeline Adult Day

MOW (Meals on Wheels) Med Mgmt Assisted Living

3. Is the client in need of 24 hour supervision? Yes No

4. Did the client receive services in the community prior to this admission? Yes No

If yes, provide agency name and services received: _____

5. Does the client have or had a case worker with Department of Elderly Affairs (DEA) or Behavioral Healthcare, development disability and Hospitals (BHDDH) or Long Term Care (LTC)? Yes No

If yes, which agency DEA BHDDH LTC

6. Does the client have a family support system? Yes No Please explain _____

7. Will client be Living alone? With others? **OR** Need Housing Assistance?

Please describe _____

8. Is there clinical documentation supporting that a transition to the community would not be appropriate for this client? Yes No

9. Have you referred this client to the Nursing Home Team previously? Yes No

If yes, have there been any changes that would now make a transition more appropriate? Yes No

Please describe: _____

10. Does client have a Legal Guardian or Power of Attorney? Yes No.

If yes, provide:

Name: _____ Phone: _____

11. Has family or guardian been notified of referral? Yes No N/A

RTH Screening Form

Completed By	Referral Coordinator
Program	NHTP and RTH
Signed by Individual	NO

This form is used by the Referral Coordinator to determine if the individual would qualify for RTH. The form consists of a decision tree, which will determine if a case should be distributed to the NHTP team or the RTH team, based on the information provided on the OCP Referral Form. The length of the Nursing Home stay may need to be verified if that information is missing from the OCP Referral Form or if some of the Nursing Home days were for short-term rehab. If LTC Medical Assistance is pending or if the individual has not yet applied, the case will still be distributed to the appropriate team. This form is required for both RTH and NHTP individuals.

Client Name: _____

MFP SCREENING FORM

Has the client been a resident of the nursing home for at least 90 consecutive days?

Yes

No → **NHTP**

Was the admission for short-term rehab?

No

Yes →

If the NH admission was initially for short-term rehab, what was the last Medicare covered day for short-term rehab? ____/____/____
Has the client been a resident for 90 days after this date?

Yes

No

Is the client already LTC Medicaid eligible?

Application Pending

Yes

No →

Is the client planning to apply for LTC Medicaid?

NHTP

Application MFP

Pending ← Yes

No →

Give to Michelle for Section Q

Please indicate to which program the client has been assigned:

MFP

NHTP

Form completed by: _____

Team Assigned to: _____ Date: ____/____/____

If LTC Medicaid Eligibility was PENDING, date application approved: ____/____/____

NHTP/RTH Protective Services History Form

Completed By	Referral Coordinator
Program	NHTP and RTH
Signed by Individual	NO

This form is completed by the Referral Coordinator based on information on the OCP Referral Form. If the OCP Referral Form indicates that the individual is known to DEA or BHDDH, the data entry clerk will contact the appropriate protective service agency to determine the name and phone number of the Case Manager. Although there is a comments section on the NHTP/RTH Protective Services History Form, the referral coordinator should limit comments so as to preserve the confidential nature of this information. Knowledge of past history of abuse, neglect or exploitation will inform the Transition Coordinator/Social Worker as she or he determines the appropriateness of the individual's transition to the community. This form is required for both NHTP and RTH individuals.

NHTP/MFP Protective Services History Form

Participant Name:	Today's Date:
Is the individual known to DEA or BHDDH Protective Services?	<input type="checkbox"/> DEA <input type="checkbox"/> BHDDH <input type="checkbox"/> None
DEA/BHDDH Case Manager Name:	Phone:
Comments:	

Case File Checklist

Completed By	TC/SW/RN
Program	NHTP and RTH
Signed by Individual	NO

This form is used by both the Transition Coordinator/Social Worker and the nurse to keep a record of the dates forms were completed and submitted and a reminder when the individuals LOC is due to be re-certified. The form should be placed at the front of the active case record. This form is required for both NHTP and RTH.

Case File Checklist
(Check box and date when completed)

Date assigned: _____ Date referral received: _____ MFP or NHT (Please circle)

SW Name: _____ RN Name: _____

- Date InRhodes inquiry completed: _____
- Date Options Counseling Provided: _____
- Date given to OCP RN: _____
- Date Comprehensive Transition Assessment complete: _____
- Date Post-Assessment Status Form submitted: _____
- Date MFP Informed Consent signed: _____
- Date Risk Mitigation Plan complete: _____
- Date Emergency backup plan developed: _____
- Date QOL referral form given to Diane: _____
- Date Plan of Care Complete: _____
- Date GWSP Completed: _____
- Date Service Calculator completed: _____
- Date case given to Housing Coordinator: _____
- Date list of Transitional Services complete: _____
- Date of Home Safety Check list complete: _____
- Date(s) monthly pending forms: _____
- Date of Transition Placement form: _____ Discharge Date: _____
- Date 24 hour phone call completed by SW: _____
- Date week 1/10 day visit is completed (SW): _____ (RN): _____
- Date week 2 visit/phone call is completed (SW): _____ (RN): _____
- Date Week 3 phone/home visit completed (SW): _____ (RN): _____
- Date 30 day/ Week 4 visit is completed (SW): _____ (RN): _____
- Date 30-day Transfer Form sent to LTC or DEA: _____
- Date(s) monthly status update: _____
- Date 365 MFP participation ended: _____

Level of Care re-cert due: _____

CTA – Community Transition Assessment

Completed By	RN
Program	NHTP and RTH
Signed by Individual	NO

The CTA is a comprehensive assessment completed by the nurse and includes elements such as: functional ability, mental state, safety concerns, community supports, behavior health status, detailed medical assessment, medications list, a list of previous services and detailed recommendations regarding home and community based services. This form is required for both NHTP and RTH.



Rhode Island Department of Human Services

COMPREHENSIVE TRANSITION ASSESSMENT

REFERRAL

Admission Date to Hospital _____ Hospital Name: _____
Admission Date to NH _____

Assessment Date: _____

Referral Type:

- NH Name: _____
NH Location: _____
NH Address: _____
NH D/C Planner: _____
Rm # _____ Floor _____
 HCBS ASL
 NH Re-Assess
 Preventive MFP
 Other: _____

Tel #: _____

CLIENT IDENTIFYING DATA

Medicare Ins Type: _____ Other Insurance: _____

Name: _____ DOB: _____ SSN: _____

Address: _____ Apt#: _____ Floor: _____

City/Town: _____ Zip: _____ Phone: _____

Primary Language: _____ Interpreter Needed: Yes No

Primary Contact Person: _____ Is this person a Legal Guardian/POA/DPOA? Yes No

(circle one)

Relationship: _____ Contact Phone: _____

Address: _____ City/Town _____ State _____ Zip _____

Veteran Yes No Occupation: _____

Marital status:

- Married Divorced Separated
 Never Married Widowed Unmarried Partner

Did Client Have Previous Involvement with DEA Protective Services? Yes No

If yes, DEA notification date: _____

Advanced directives _____

INFORMAL SUPPORTS (FAMILY, FRIENDS, ETC.)

Table with 3 columns: Name, Relationship, Contact Information

PRE NH ADMISSION LIVING ARRANGEMENTS

Housing Status

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> State Institution | <input type="checkbox"/> Group Home | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Own Home | <input type="checkbox"/> Rents Home | <input type="checkbox"/> Subsidized Apt | |
| <input type="checkbox"/> Lives Alone | <input type="checkbox"/> Lives w/ Spouse | <input type="checkbox"/> Lives w/ Children | <input type="checkbox"/> Lives w/ Parents |

Pt Living Preference: _____

RN Clinical Recommendation: _____

POST NH ADMISSION LIVING ARRANGEMENTS

- | | |
|--|---|
| <input type="checkbox"/> Home w/ Family | <input type="checkbox"/> Group Home |
| <input type="checkbox"/> Home Alone | <input type="checkbox"/> Needs Housing Assistance |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Other: _____ |

LTC ELIGIBILITY REQUIREMENTS

LOC complete? Yes No Date: _____

LTC Social Worker: _____ Office Location: _____ Ph: _____

Does the client have a co-share? \$ _____ MA Eligibility Status: _____

Who pays Medicare B? _____ Estimated Income: _____

PREVIOUS HOME BASED SERVICES

Services Client Receives	Provider Name	# of hours/days per wk
<input type="checkbox"/> Homemaker		
<input type="checkbox"/> CNA		
<input type="checkbox"/> Skilled Services		
<input type="checkbox"/> MOW		
<input type="checkbox"/> Hospice Care		
<input type="checkbox"/> Mental Health Services		
<input type="checkbox"/> Senior Center		
<input type="checkbox"/> Adult Day Center		
<input type="checkbox"/> Med Reminding/Cueing		
<input type="checkbox"/> Transportation		
<input type="checkbox"/> DME		
<input type="checkbox"/> ERS		

Recommendations: _____

FUNCTIONAL ABILITY/ADL'S

Key

0=Independent

1=Supervision

2=Limited Assistance

3=Extensive Assistance

4=Total Dependence

5=Activity did not occur

1. _____ Supports for eating _____ Supports for preparing meals Comments: _____
2. _____ Supports for toileting Comments: _____
3. _____ Supports for mobility (specify with or without manual aid) _____ Supports for transferring Comments: _____
4. _____ Supports for personal hygiene/grooming _____ Supports for dressing _____ Supports for bed bath _____ Supports for showering _____ Supports for special skin care Comments: _____
5. _____ Supports for light housekeeping (including laundry) _____ Supports for heavy housework Comments: _____
6. _____ Supports for transportation _____ Supports for shopping Comments: _____
7. _____ Supports for finances _____ Supports for telephone ability Comments: _____
8. _____ Identify the degree of support needed in an emergent situation _____ Identify the degree of support needed during the night Comments: _____
9. _____ Supports for medication preparation _____ Supports for medication management Comments: _____

Communication:

Is client able to speak and verbally express him/herself? Yes No

Comments: _____

Name devices the client uses to communicate/understand others:

BEHAVIORAL HEALTH

(Check all that apply)

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Agitated | <input type="checkbox"/> Disoriented | <input type="checkbox"/> Resistant to care |
| <input type="checkbox"/> Alert | <input type="checkbox"/> Disruptive @ times | <input type="checkbox"/> Verbally Abusive & threatening |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Pleasant & cooperative | <input type="checkbox"/> Other: _____ |

ETOH/Substance Use: _____ How often: _____ Meetings: _____

Mini Mental/BIMS Score: _____ Date _____

Comments: _____

PASRR Yes No Date: _____ Information provided by: _____

REHAB SERVICES

Is the client receiving? PT OT ST (circle all that apply) Dates: _____

Was a home evaluation completed? Yes No

Recommendations: _____

RISKS

Does the client have a history of falls? Yes No Other: _____

HEARING & VISION

Hearing impaired Yes No Assistive devices Comments: _____

Vision impaired Yes No Glasses or device

Indicate client's current vision quality (w/ glasses if used regularly):

- | | |
|---|---|
| 1) <input type="checkbox"/> Adequate – sees fine print | 2) <input type="checkbox"/> Impaired – sees larger print |
| 3) <input type="checkbox"/> Mod Impaired – limited vision | 4) <input type="checkbox"/> Highly Impaired – sees only light/shadows |

DIET

Diet: _____

NPO: _____ Parental: _____

Special instructions/preparations: _____

Comments: _____

Able to chew Able to swallow Aspiration precautions
 Own teeth Dentures Partial plate

Comments: _____

Name of dentist: _____ Date of last visit: _____

HEIGHT/WEIGHT

Weight: _____ Height: _____

Recent gain: Yes No Recent loss: Yes No

HEALTH CARE PROVIDERS / SPECIALISTS

Type (PCP/ Specialist/ Clinic)	Name/Practice	Phone	Address
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Behavioral Health Providers			
Dentist			
Other: _____			
Other: _____			

PCP appointment after discharge: Date _____ Time _____

Other appointments: _____

SLEEP

Is client satisfied w/ sleep quality? Yes No # of hours per night _____

Comments:

MEDICAL ISSUES

Diagnosis: _____

- | | | | | |
|---|-----------------------------------|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> CHF | <input type="checkbox"/> GI issues | <input type="checkbox"/> MS | <input type="checkbox"/> Seizure d/o |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Cancer
<input type="checkbox"/> Chemo/radiation | <input type="checkbox"/> CVA | <input type="checkbox"/> HTN | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune disorder | <input type="checkbox"/> Renal
<input type="checkbox"/> Dialysis | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> O ₂ LF _____ | | | | |

Comments:

Surgical History

Dates

Smoking: Yes No Do others smoke in the home? Yes No

Quit: Yes No If yes, how long? _____

Cessation Classes: Yes No

Are there pets in the home? Yes No

ELIMINATION

Urinary:

<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Ostomy	<input type="checkbox"/> Dialysis
_____ toilet	_____ briefs/pull ups		Type: _____
_____ commode	_____ texas catheter		Treatment Site: _____
_____ bedpan	_____ indwelling catheter		Times/Wk: _____
_____ urinal	_____ intermittent catheterization		

Comments: _____

Bowels:

<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Ostomy
_____ toilet	_____ briefs/pull ups	
_____ commode		
_____ bedpan		

Comments: _____

PAIN

Location: _____

Intensity: verbal facial 0 1 2 3 4 5 6 7 8 9 10
(none) (moderate) (Severe)

Does pain interfere with ADLs? Yes No

Frequency: _____ Duration: _____

Relieved w/: _____

Outcome: _____

DIABETES

Glucometer: _____ Frequency: _____

B.S. range: _____ Hgb A1C: _____ Checked every _____

Podiatrist: _____

Diabetic shoes: _____ Diabetic teaching: _____

LABS

Tests: _____

Location: _____ Frequency _____

Client/Family Teaching: _____

TRANSITION RECOMMENDATIONS

Referral Options

Planned NH Discharge Date: _____

Case Management will be referred to: DEA LTC Field Office BHDDH Preventive CCC
(for NHTP client only)

Medically Complex Other: _____

Client referred to: DEA Core DHS Core AL BHDDH

Preventive Personal Choice HAB PACE

SL Other: _____

Recommended Home Based Service

Services	Provider Name	# hours/days per wk
<input type="checkbox"/> Homemaker		
<input type="checkbox"/> CNA		
<input type="checkbox"/> Skilled Services		
<input type="checkbox"/> MOW		
<input type="checkbox"/> Hospice Care		
<input type="checkbox"/> Mental Health Services		
<input type="checkbox"/> Senior Center		
<input type="checkbox"/> Adult Day Center		
<input type="checkbox"/> Med Reminding/Cueing		
<input type="checkbox"/> Transportation		
<input type="checkbox"/> DME		
<input type="checkbox"/> ERS		
<input type="checkbox"/> Respite		
<input type="checkbox"/> Senior Companion		
<input type="checkbox"/> Coumadin Therapy		

Required Medical Equipment	Date Ordered
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	

CMA- Case Management Assessment

Completed By	TC/SW
Program	NHTP and RTH
Signed by Individual	NO

The Case Management Assessment is completed by the TC/SW for a request in change of service or at the annual assessment date. The CMA assesses the individual's functional ability, mental state, safety concerns, community supports and recommendations for ongoing services.



Rhode Island Department of Human Services
Rhode Island Department of Elderly Affairs

CASE MANAGEMENT ASSESSMENT

REFERRAL

Assessment Date: _____ Referral Type: HCBS Nursing Preventive Initial

Effective Date: _____ Re-Assess Sherlock Plan Other

Location: Home NH Other (specify: _____)

Social Caseworker: _____ Tel. No.: _____

Agency/Unit: _____

CLIENT IDENTIFYING DATA

Name: _____ DOB: _____ SSN: _____

Address: _____ Apt#: _____ Floor: _____

City/Town: _____ Zip: _____ Telephone Number: _____

Primary Language: _____ Interpreter Needed: Yes No

Primary Contact Person: _____ Caregiver: Yes No

Relationship _____ Contact Telephone Number _____

Address: _____ City/Town _____ State _____ Zip _____

LIVING ARRANGEMENTS

Lives Alone Nursing Home _____ Admission Date

Subsidized Housing Group Home _____ Admission Date

With Others Residential/Assisted Living _____ Admission Date

Please specify relationship: _____

FUNCTIONAL ABILITY

A. HOMEMAKING CAPABILITIES (Please use Functional Codes)

<u>Functional Codes</u>	* Explain Limitations/Extra Needs
_____	Cleaning _____
_____	Laundry _____
_____	Shopping _____
_____	Meal Preparation _____

B. PHYSICAL FUNCTIONAL ABILITIES (Please use Functional Codes)

<u>Functional Codes</u>	* Explain Limitations/Extra Needs
_____	Ambulation _____
_____	Transfers _____
_____	Bathing _____
_____	Dressing _____
_____	Eating _____
_____	Toileting _____
_____	Medication Management _____

Comments: _____

CODE KEY To Be Used When Completing Assessment Forms

Code for individual's actual level of involvement in self-care over 24 hours for the last 7 days.

0 = Independent -No help or oversight -- **OR** -- help/oversight provided only 1 or 2 times during the last seven days.

1 = Supervision - Oversight, encouragement or cueing provided 3 or more times --**OR-** Supervision (3 or more times) plus limited physical assistance provided only 1 or 2 times during the last seven days.

2 = Limited Assistance -Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times --**OR-** Limited assistance (3 or more times) plus extensive assistance provided only 1 or 2 times in the last 7 days.

3 = Extensive Assistance -While individual performed part of activity, weight-bearing support or full caregiver performance 3 or more times over part (but not all) of the last seven days.

4 = Total Dependence -Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would **NOT** be coded as a "4" Total Dependence.

Equipment Needed: _____

Comments: _____

C. MENTAL STATUS (Check all that apply)

- Alert Disoriented Forgetful Verbally abusive or threatening
- Agitated Depressed Withdrawn Confused
- Anxious Disruptive Pleasant and cooperative

SCW Observation/Source of Information: _____

D. HEARING, SPEECH & VISION

Hearing Impaired: Yes No Speech Impaired: Yes No Vision Impaired: Yes No

Comments: _____

E. ENVIRONMENTAL/SAFETY CONCERNS: Please check off those that apply:

- Dangerous stairs or floors Poor lighting and/or electrical wiring
- Heating or cooling Problems with water, plumbing or septic system
- Major appliances (including refrigerator) Odor or pests
- Stairs to enter or leave house Obstacles within home
- Obstruction to entrance of home Inadequate locks on doors and/or windows
- Other (please describe other safety concerns): _____

RECENT ACCIDENTS/FALLS:

F. INFORMAL SUPPORTS (FAMILY, FRIENDS, ETC.)

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>CONTACT INFORMATION</u>
_____	_____	_____
_____	_____	_____

Pet(s): Yes No Type(s): _____

HEALTH CARE AND COMMUNITY SUPPORTS

Services

Provider(s)

- Physician
- Specialist
- Dentist
- Skilled Nursing / P.T. / O.T. / Speech
- Medical Equipment
- Mental Health/Substance Abuse
- Out-Patient Treatment
(Radiation/Chemotherapy/Dialysis)
- Medication Reminder/Cueing
- Adult Day Care
- Senior Center
- Meal Site
- Transportation
- Other

SUMMARY / RECOMMENDATIONS (Give reasons for level of care/need for services). Include caregiver's participation in care plan.

Signature of Social Caseworker

Date

DHS Authorization to Obtain or Release Confidential Information (Agency Release)

Completed By	RN
Program	NHTP and RTH
Signed by Individual	YES

This form is completed by the OCP/RTH nurse. It is also signed by the individual and is the written authorization to share personal information with service providers. This form is required for both NHTP and RTH.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

This form is not intended to be used as a Medical Release form.
Please **do not** include any Medical information on this form.

I hereby authorize the Rhode Island Department of Human Services to obtain from, or release to:

Name _____
Person, Agency, or Organization

Address _____

the following information pertinent either to me or to the person listed below for whom I am responsible:

Financial _____
(Specify) _____ (Dates) _____

Social _____
(Specify) _____ (Dates) _____

Other _____
(Specify) _____ (Dates) _____

Name (printed) _____
Person about whom information is requested

Date of Birth _____ **Social Security Number** _____ **VA Claim Number** _____

Address _____

Reason for Request _____

I understand that records are protected under the General Laws of Rhode Island and cannot be disclosed without written consent, except as otherwise specifically provided by the law. Any information released or received as a result of this consent shall not be further relayed in any way to any person, or organization outside of the department, without an additional written consent from me, unless it is for the purpose of processing my application for assistance or services. This consent is voided at the termination of assistance or withdrawal from services or can be terminated at any time.

Signature of Client, Parent, or Guardian Relationship to above Date

Name (printed) DHS Agency Representative Title

District Office Address _____

DHS Authorization for Disclosure/Use of Health Information (Medical Release)

Completed By	RN
Program	NHTP and RTH
Signed by Individual	YES

This form is completed by the OCP/RTH nurse. It is also signed by the individual and is the written authorization to share medical information with another agency or provider. One of these forms should be completed and signed for each agency that will be providing medical services to the individual (e.g. home care agency). This form is required for both NHTP and RTH.

RI DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I, (Name of Applicant/Patient), hereby voluntarily authorize the disclosure of information from my record.

My Date of Birth: / /

My Social Security Number: - -

II. My information is to be disclosed by:

And is to be provided to:

(Name of Person/Organization)
(Address)
(City, State, ZIP)

(Name of Person/Organization)
(Address)
(City, State, ZIP)

III. The purpose or need for this release of information is:

- I am applying for Medical Assistance
I am applying for other DHS Services
My own personal and private reasons
Other (specify):

IV. The information to be disclosed: (check only ONE of the following boxes)

- Entire Health Record
Health Insurance Information
All of the information (except the boxes I checked) in Section VI below
Other (specify):
Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)

I would also like the following sensitive information disclosed (check the applicable box(es))

- Alcohol/Drug Abuse Treatment/Referral
Sexually Transmitted Diseases
HIV/AIDS-related Treatment
Mental Health (Other than Psychotherapy Notes)

V. I understand that if I am applying for enrollment, recertification, or other services, this release covers all my medical/health care providers, including the provider named above as well as any other person, facility, program or plan I have told you about on my written applications(s) for Department of Human Services programs, and on the necessary DHS forms, specifically the AP-70 forms and the MA-63 forms. I understand further that this authorization is required as a condition of obtaining eligibility and services and shall be used by DHS only for such purposes. Therefore, failure on my part to sign this authorization may affect my eligibility and/or the scope of services I may obtain. Additionally, I agree to the use of a fax or a photocopy of this form for the release or disclosure of the information.

I also understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES and that, if I do, DHS may condition my eligibility and access to services on my decision to revoke. In addition, any information disclosed to DHS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below.

(Enter if different from one year after the date below)

Signature of Patient

Date

Signature of Authorized Representative

Relationship to Patient

Date

VI. Specific Information I do NOT want disclosed: (check the applicable box(es))

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Discharge Summary w/lab data | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Data | <input type="checkbox"/> Psychiatric Exam |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Psychological Test | <input type="checkbox"/> Social Service History |
| <input type="checkbox"/> Vocational | <input type="checkbox"/> Medical | <input type="checkbox"/> Educational | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Minimum Data Set | <input type="checkbox"/> Nurses' Notes | <input type="checkbox"/> Care Plans | <input type="checkbox"/> Dental Records |
| <input type="checkbox"/> Photos/Videos/Digital Images | <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Consultant Reports | <input type="checkbox"/> Dietary Records |
| <input type="checkbox"/> Emergency Care Records | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Diagnostic Results | |

**Instructions for Completing Form DHS-25M
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

1. Print legibly in all fields using black ink.
2. Section I – print name of the patient whose information is to be released.
3. Section II – print the name and address of the person/organization authorized to release the information. Also, provide the name of the person, unit and address that will receive the information.
4. Section III – state the reason why the information is needed (e.g., disability claim, continuing medical care)
5. Section IV – check ONE of the listed boxes.
 - a. Entire Record – the patient's complete medical record except for the sensitive information (e.g., alcohol/drug abuse treatment referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health/ other than psychotherapy notes)
 - b. All of the information (except the boxes I checked) in Section VI below – the patient should check only those boxes the patient does NOT wish to have disclosed
 - c. Other (specify) – specific information specified by the patient (e.g., CHS, billing, employee health)
 - d. Psychotherapy Notes **ONLY** – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use ~~or~~ disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
 - e. **RELEASE OF SENSITIVE INFORMATION** – check alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases, mental health (other than psychotherapy notes) – patient must check the appropriate box!
6. Section V – sign and date. If a different *expiration* date is desired, specify a new date.
7. Section V – Authorized Representative (e.g., legal guardian, power of attorney)
8. Section VI – Specific information the patient does NOT want disclosed.
9. A copy of the completed Form DHS-25M will be given to the patient.

Service Calculator Tool

Completed By	RN
Program	NHTP/RTH
Signed by Individual	NO

This manual includes a printed version of the Service Calculator Tool. Each clinical staff person has the Service Calculator Tool as a spreadsheet on their desktop. This tool helps to determine the amount of services to be received and the associated cost, for each NHTP/RTH individual.

DATE:

INDIVIDUAL'S NAME:

SOCIAL WORKER/CASE

MANAGER:

	Cleaning	Laundry (off site)**	Laundry (in Home)	Shopping***	Meal Prep	Ambulation	Transfers	Bathing	Dressing	Eating	Toileting	Totals
Minutes Allowed	30	30	30	25	30	30	30	30	30	30	30	300
Times per day	0	0	0	0	0	0	0	0	0	0	0	0
Days per week	0	0	0	0	0	0	0	0	0	0	0	0
Level of Assistance												
0 = Independent	X	X	X	X	X	X	X	X	X	X	X	
1 = Minimum / Supervision												
2 = Moderate / Limited Assist												
3 = Maximum / Extensive Assistance												
4 = Total / Total Dependence												
Total Minutes Per Day	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Minutes Per Week	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Hours per day	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Hours per week	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CMA Total Hours Per Month	(Total hours per week x 4.33)											

* Minutes Allowed: The numbers represented are maximum minutes allowed per task (allowable minutes)

** Laundry: Only enter information in EITHER the "Laundry (Off Site)" OR the "Laundry (In Home)". Cannot enter information in both columns, must complete only one of the laundry columns.

*** Laundry (Off Site): Limit is 1 time per day AND 1 time per week

*** Shopping: Limit is a max of 1 time per day AND 2 times per week

Functional Impairment Calculator												
	Cognitive	Endurance	Pain	Open Wound	Spasticity	Muscle Tone	Fine Motor Deficit	Decreased	Impairment	Endurance	Pain	Open Wound
Minutes Allowed	30	30	30	30	30	30	30	30	30	30	30	30
Times per day	0	0	0	0	0	0	0	0	0	0	0	0
Days per week	0	0	0	0	0	0	0	0	0	0	0	0
Level of Assistance												
0 = Independent	X	X	X	X	X	X	X	X	X	X	X	X
1 = Minimum / Supervision												
2 = Moderate / Limited Assist												
3 = Maximum / Extensive Assistance												
4 = Total / Total Dependence												
Total Minutes Per Day	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Minutes Per Week	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Hours per day	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Hours per week	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CMA Total Hours Per Month	(Total hours per week x 4.33)											

This calculation is made to represent those functional limitations that add substantial time necessary to complete the task (beyond the level of assistance noted above). Individuals must have a documented diagnosis and supporting documentation outlining how the individual's functional impairment significantly impacts their ability to perform the tasks outlined above.

Examples of qualifying functional impairments include:

- Behavioral Issues, Limited Range of Motion, Spasticity/ Muscle Tone, Fine Motor Deficit, Cognitive Impairment, Decreased Endurance, Pain, Open Wound,

HOURS IN EXCESS OF 7 HOURS PER DAY (49 HOURS PER WEEK OR 212.31 PER MONTH)	Signature	Date
REQUIRE APPROVAL FROM SUPERVISOR		

Department of Human Services Individual Plan of Care (GW-SP)

Completed By	RN
Program	NHTP
Signed by Individual	YES

This form is completed by the nurse. It outlines the specific care plan that has been approved for an NHTP individual. It includes cost and individual share information and should be signed by the individual. This form will be entered into the Community Supports Management System (CSM) by the Data Entry Clerk.

**DEPARTMENT OF HUMAN SERVICES
INDIVIDUAL PLAN OF CARE**

NAME: _____ CASE# _____ DATE: _____

WAIVER START DATE: _____

SCW: _____ RL: _____ TEL: _____ FAX: _____

<input type="checkbox"/> INITIAL ASSESSMENT	<input type="checkbox"/> REASSESSMENT	<input type="checkbox"/> CHANGE	<input type="checkbox"/> CORE	<input type="checkbox"/> PREVENTIVE	<input type="checkbox"/> DEA
---	---------------------------------------	---------------------------------	-------------------------------	-------------------------------------	------------------------------

1. Service:	PERSONAL CARE
Provider:	_____
Provider:	_____
Frequency:	_____
2. Service:	HOMEMAKING SHOPPING, MEALS
Provider:	_____
Provider:	_____
Frequency:	_____
3. Service:	MEALS ON WHEELS
Provider:	_____
Frequency:	_____
4. Service:	ERS
Provider:	_____
5. Provider:	MINOR ASSISTIVE DEVICES
Device:	_____

6. Service:	ADULT DAY CARE
Provider:	_____
Frequency:	_____
7. Service:	CASE MANAGEMENT
Provider:	_____
Frequency:	_____
8. Service:	RESPIRE SERVICE
Provider:	_____
Frequency:	_____
9. Service:	SENIOR COMPANION
Provider:	_____
Frequency:	_____
10. Service:	OTHER*
Provider:	_____
Frequency:	_____

TOTAL HHA HOURS: _____ /MONTH CLIENT'S MONTHLY SHARE \$: _____

* Other CORE services: Comm. Transition Services, Shared Living, Assisted Living (L or F), Private Duty Nursing, Respite, PT/OT.

	Waiver Service	Base Rate	Hours Per Week	Month/Total
1.	PERSONAL CARE	\$ 17.24/HR	(X 4.333)	
2.	HOMEMAKING, SHOPPING, MEALS	\$ 16.16/HR	(X 4.333)	
	COMBINED	\$ 16.64/HR	(X 4.333)	
3.	MEALS ON WHEELS	\$ 4.50/MEAL	Meals per month	
4.	ERS	\$ 35.00/MONTH		
5.	MINOR ASSISTIVE DEVICES	\$		
6.	ADULT DAY CARE	\$	***Included in State Plan***	-0-
7.	CASE MANAGEMENT	\$ 60.00/HR		
8.	RESPIRE SERVICES	\$		
9.	SENIOR COMPANION	\$ 8.50/HR	(X 4.333)	
10.	OTHER*	\$		
TOTAL:				

Participant/Representative Signature

SCW/Supervisor Signature

Rhode to Home Care Plan (1. Service Plan, 2. Risk and Mitigation Plan, 3. Emergency Back-up Plan)

Completed By	RN/TC
Program	RTH
Signed by Individual	YES

This is the comprehensive care plan for RTH individuals. It includes a service plan which identifies the needs of the individual, the designated service provider or informal support to address those needs, the frequency in which the support or service will be provided and a goal that addresses each area. The RTH home care plan also includes an individualized risk assessment with a mitigation plan that addresses each identified risk with an individualized plan to mitigate or prevent those risks from occurring. The last part of the RTH home care plan is the Emergency backup plan. This plan is developed in collaboration with the individual and any family, friend and/or caregiver. There is also a basic information form that is also completed in conjunction to this plan and this is the coversheet that is used when sending the emergency backup plan to the Alliance. The entire Care Plan is person centered which means the individual or their guardian takes an active part in developing the care plan and the plan is based on personal preference, choice and interests. The TC and the RN work collaboratively in putting all components of the care plan together.

**MFP -THE RHODE TO HOME
CAREPLAN
PART 1. SERVICE PLAN**

MFPCP-1
Rev: 12/30/11

Name: _____ Case#: _____ Date: _____

<input type="checkbox"/> Initial Assessment	<input type="checkbox"/> Reassessment	<input type="checkbox"/> Change
---	---------------------------------------	---------------------------------

<input type="checkbox"/> DHS Core	<input type="checkbox"/> Preventative	<input type="checkbox"/> DEA Core	<input type="checkbox"/> Personal Choice	<input type="checkbox"/> HAB	<input type="checkbox"/> BHDDH
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I. SERVICES

1. Goal: Service: Provider: Provider: Frequency: Duration:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Personal Care</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Personal Care				
Personal Care							
2. Goal: Service: Provider: Provider: Frequency: Duration:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>House Hold Tasks</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		House Hold Tasks				
House Hold Tasks							
3. Goal: Service: Provider: Frequency:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Meals on Wheels</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Meals on Wheels				
Meals on Wheels							
4. Goal: Service: Provider: Frequency: Duration:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Emergency Response System</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Emergency Response System				
Emergency Response System							
5. Goal: Service: Provider: Device: Device:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Minor Assistive Devices</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Minor Assistive Devices				
Minor Assistive Devices							
6. Goal: Service: Provider: Frequency: Duration:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Medication Management</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Medication Management				
Medication Management							

7. Goal: Service: Provider: Frequency: Duration:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Adult Day Care</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Adult Day Care			
Adult Day Care						
8. Goal: Service: Provider: Frequency: Duration:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Case Management</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Case Management			
Case Management						
9. Goal: Service: Provider: Frequency:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Respite Service</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Respite Service			
Respite Service						
10. Goal: Service: Provider: Frequency: Duration:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Senior Companion</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Senior Companion			
Senior Companion						
11 Goal: Service: Provider: Provider: Frequency:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Transportation</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Transportation			
Transportation						
12. Goal: Service: Provider: Frequency: Duration:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td>Other:</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		Other:			
Other:						

**MFP -THE RHODE TO HOME
CAREPLAN
PART 1. SERVICE PLAN**

<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20%;">13.Goal:</td><td></td></tr> <tr><td>Service:</td><td>Home Modification</td></tr> <tr><td>Provider:</td><td></td></tr> <tr><td>Frequency:</td><td></td></tr> <tr><td>Duration:</td><td></td></tr> </table>	13.Goal:		Service:	Home Modification	Provider:		Frequency:		Duration:		<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20%;">15.Goal:</td><td></td></tr> <tr><td>Service:</td><td>Mental Health/ BH Need</td></tr> <tr><td>Provider:</td><td></td></tr> <tr><td>Frequency:</td><td></td></tr> <tr><td>Duration:</td><td></td></tr> </table>	15.Goal:		Service:	Mental Health/ BH Need	Provider:		Frequency:		Duration:	
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* Other CORE services: Comm. Transition Services, Shared Living, Assisted Living (L or F), Private Duty Nursing, Respite, PT/OT.

	Waiver Service	Base Rate	Hours Per Week	Month/Total
1	PERSONAL CARE	\$ 17.24/HR	(X 4.333)	
2	HOMEMAKING, SHOPPING, MEALS	\$ 16.16/HR	(X 4.333)	
	COMBINED	\$ 16.64/HR	(X 4.333)	
3	MEALS ON WHEELS	\$ 4.50/MEAL	Meals per month	
4	ERS	\$ 35.00/MONTH		
5	MINOR ASSISTIVE DEVICES	\$		
6	ADULT DAY CARE	\$	*** Included in State Plan***	-0-
7	CASE MANAGEMENT	\$ 60.00/HR		
8	RESPITE SERVICES	\$		
9	SENIOR COMPANION	\$ 8.50/HR	(X 4.333)	
10	OTHER*	\$		
TOTAL:				

TOTAL HHA HOURS: _____ /MONTH **CLIENT'S MONTHLY SHARE \$:** _____

Participant/Representative Signature

SCW/Supervisor Signature

MFP- THE RHODE TO HOME
CARE PLAN
PART 2. RISK AND MITIGATION PLAN

MFPCP-2
Rev: 12/30/11

I. Primary Care

Physical Health

Strengths: (check all that apply)

- Supports available to assist with physical limitations
- Current medical diagnoses are being followed by medical professionals
- Currently has ability to manage physical health within the community with assistance
- Access to medical testing and health reports are available

Needs: (check all that apply)

- No available supports to assist with physical limitations
- Medical professional assistance is needed to follow current diagnoses
- Currently unable to manage physical health within the community even with assistance
- Access to medical testing is delayed or unavailable
- Access to medical reports is delayed or unavailable

Needs Interventions:

1. _____
2. _____
3. _____
4. _____

Mental Health

Strengths: (check all that apply)

- Supports available to assist with mental health diagnosis
- Current mental health diagnoses are being followed by medical professionals
- Client has ability to manage mental health diagnosis within the community with assistance
- History of Substance Abuse issues and currently sober for +1 yr
- Client has access to substance abuse supportive services in facility/community

Needs: (check all that apply)

- No available supports to assist with mental health diagnosis
- Mental health professional assistance is needed to follow current diagnoses
- Currently unable to manage mental health diagnosis within the community even with assistance
- Current substance abuse issues, or history of substance abuse issues w/ less than 1 yr. sobriety
- Diagnosis of Dementia or Cognitive issues
- Client has no access to substance abuse supportive services in facility/community
- Other Mental Health/Cognitive Issues (explain below)

Needs Interventions:

1. _____
2. _____
3. _____
4. _____

**MFP- THE RHODE TO HOME
CARE PLAN
PART 2. RISK AND MITIGATION PLAN**

II. Human Services

Consumer Engagement and Awareness

Strengths: (check all that apply)

- Client is able to advocate for their own needs and/or has supports to assist in advocating
- Client is aware/accepting of limitations and is motivated to participate in their transition planning
- Client is aware and can demonstrate appropriate use of Independent Living Skills

- Client is able to communicate despite language barriers or limitations

Needs: (check all that apply)

- Client is unable/unaware or unmotivated to advocate for their own needs
- Client is unaware or has unrealistic view of their own limitations and needed supports
- Client has a lack of or cannot demonstrate appropriate knowledge/use of Independent Living Skills
- Client has limitations with communication skills or language
- Other engagement/awareness issues (explain below)

Needs Interventions:

1. _____
2. _____
3. _____
4. _____

Services, Supports and Financial

Strengths: (check all that apply)

- Client has appropriate access to transportation services
- Client has access to supportive health aid services while in facility and will need community supportive services
- Client has appropriate assistive technology and **DME** available at a facility and in the community
- Client has appropriate informal supports (friends, family, etc.)
- Client has approved Long Term Care Assistance
- Client has income/resources that are appropriate to support their needs

Needs: (check all that apply)

- Client has a lack of appropriate transportation services
- Client has a lack of supportive health aid services/ assistance in facility or community
- Client has a lack of appropriate assistive technology and **DME** available at a facility or in community
- Client has a lack of appropriate informal supports (friends, family etc.)
- Client lacks appropriate health insurance benefits
- Client lacks appropriate financial resources to support their needs
- Client has unpaid/past due bills and no resources for payment
- Other Supportive Services Issues (explain below)

Needs Interventions:

1. _____
2. _____
3. _____
4. _____

**MFP- THE RHODE TO HOME
CARE PLAN
PART 2. RISK AND MITIGATION PLAN**

III. Formal and Informal Supports

Waiver Program, MFP Office or Transition Coordination

Strengths: (check all that apply)

- Client has applied and been accepted for Waiver Program (specify Waiver program below)
- Client has applied and been accepted for MFP Services
- Clients friends and/or family members are supportive and involved in the transition planning
- Transition Team, agency staff, facility staff are supportive and involved in the transition planning

Needs: (check all that apply)

- Client is ineligible for or denial of Waiver Services (specify Waiver program below)
- Current Waiver programs do not meet clients needs
- Awaiting referral approval, evaluation, etc. from Waiver Office, MFP Office, or agency.
- Transition plan not approved

- Facility/Agency coordinator(s) have not been available for follow-up referrals
- Physicians, Mental Health providers, Facility staff, State Agencies are opposed/unresponsive to transition plan
- Family and friends are unsupportive/unresponsive to transition planning
- History or current DEA involvement, and/or DEA referral advised.
- Client declines services

Needs Interventions:

1. _____
2. _____
3. _____
4. _____

IV. Recreational and Cultural Supports

Strengths: (check all that apply)

- Client has appropriate access and opportunity to cultural and recreational events (facility/community)
- Client has supportive family and friends of similar cultural background
- Client participates in cultural and/or recreational events

Needs: (check all that apply)

- Client has no access to cultural and/or recreational events (facility/community)
- Client is unmotivated/unwilling to participate in social events
- Client has language and/or communication barriers
- Other Recreational or Cultural Issues (explain below)

Needs Interventions:

1. _____
2. _____
3. _____
4. _____

MFP- THE RHODE TO HOME
CARE PLAN
PART 2. RISK AND MITIGATION PLAN

V. Special Needs and Referrals

Legal or Criminal Issues

Strengths: (check all that apply)

- Client has no current legal issues pending
- Client has copies of all appropriate legal documentation (birth certificate, SS card, Identification card, etc)
- Client has no criminal history

Needs: (check all that apply)

- Client has a history of criminal involvement
- Client has probate court issues pending
- Client is missing or waiting for appropriate legal documentation (birth certificate, SS card, ID card, etc.)
- Other Legal/Criminal Issues (explain below)

Needs Interventions:

1. _____
2. _____
3. _____
4. _____

BHDDH and Special Circumstances

Strengths: (check all that apply)

- Client is eligible for BHDDH services
- Client is motivated and involved in referral process for specialized treatment facilities/program
- Client referral is needed for specialized placement in a Supervised Mental Health Facility/Residential program
- Client referral is needed for Substance Abuse treatment facility or Sober House

Needs: (check all that apply)

- Awaiting referral approval, evaluation, etc from BHDDH
- Client is unwilling/unmotivated to participate in specialized placement referral process.
- Other Special Circumstances/Referrals (explain below)

Needs Interventions:

1. _____
2. _____
3. _____
4. _____

BASIC INFORMATION FOR MFP PARTICIPANTS

PERSONAL INFORMATION		
Individual's Name	Date of Birth	County
Address		Telephone No.
City	State	Zip Code
Primary Physician Name		Primary Physician Phone Number
Pharmacy Name and Address		Pharmacy Phone Number
Preferred Hospital and Address		Hospital Phone Number
Name/Phone of Person or Guardian with Medical Durable Power of Attorney for Health Care Decisions		Religious Preference (if applicable)
Special Instructions for Communication (Interpreter Phone Numbers, etc.)		Primary Diagnosis
Functional Information		Communication Needs

LIST OF SERVICES AND/OR SUPPORTS NEEDED FOR THE HEALTH, SAFETY AND WELL-BEING OF PARTICIPANT

Critical Services/Supports	Frequency/Description
Home Health Services (personal care and home health aide)	
Skilled Nursing Services	
Transportation	
Home Medical Equipment	
Other:	
Other:	

Transition Coordinator Name: _____

Phone: 401-462-1841

PART 3. EMERGENCY BACK-UP PLAN

LEVEL 1: MY OWN BACK-UP (e.g. Family, Guardian, Friends/Neighbors, etc.)		
Name	Relationship	Phone Number
LEVEL 2: MY SERVICE PROVIDER(S)		
Service/Support	Agency Name	Phone Number
Home Health Agency (personal care and home health aide)		
Skilled Nursing Services		
Transportation		
Home Medical Equipment		
Other:		
Other:		
LEVEL 3: WHEN LEVEL 1 AND LEVEL 2 ARE NOT ABLE TO ASSIST I SHOULD CONTACT		
Name	Hours of Operation	Phone Number
Alliance for Better Long Term Care	24 hours a day/ 7 days a week Including nights, weekends and Holidays	401-533-0506

.....

I understand how to activate my Emergency Backup Plan.

Signature of Individual/Guardian

Date

I have reviewed this Emergency Backup Plan with the MFP participant.

Signature of Transition Coordinator

Date

PART 3. EMERGENCY BACK-UP PLAN

IMPORTANT NUMBERS

Type of Emergency	Agency	Phone Number
All Types of Emergent Situations	Police/Fire Rescue	911
Reports of abuse, neglect and exploitation for individuals under 60 and disabled	BHDDH	401-462-2629
Reports of abuse, neglect and exploitation for individuals 60 and older	DEA Protective Services	401-462-0555
Program for Elders experiencing a crisis	DEA After Hours Program for Elders in Crisis	401-462-3000
For complaints about Assisted Living Residences, Nursing Homes, Home Care Agencies & Hospice	Alliance for Better Long Term Care	401-785-3340
Complaints against a licensed health care professional or healthcare facility	Department of Health	401-222-5200
Information helpline to locate resources in your community regarding issues with heating, food, housing, mental health services or other community services	United Way 211	211

Reporting Critical Incidents to the Alliance for Better Long Term Care 401-533-0506

Available 24 hours a day, 7 days a week, including nights, weekends and holidays

Should any of the below situations occur either you or your caregiver should call, within 24 hours or earliest possible time thereafter, the Alliance for Better Long Term Care

*Please refer to the Critical Incident Reporting Fact Sheet for specific definitions of the following:

- Hospitalization
- ER visit
- Involvement with criminal justice system
- Medication administration error(that results in an ER visit or hospitalization)
- Natural disaster (that leads to housing displacement)
- Missing person
- Attempted suicide
- Death

.....

MFP Transition Coordinator: _____ **Phone: 401-462-1841**
Available Monday-Friday 8:00am-4:00pm

24-Hour Emergency Backup Plan Fact Sheet

Completed By	
Program	RTH
Signed by Individual	NO

This fact sheet explains the process of activating an individual's 24-hour Emergency Backup Plan. It should be left with the individual along with a copy of their Care Plan Part 3. Emergency Back-up Plan.

Your 24-Hour Emergency Backup Plan for Services and Supports

As part of your 24-Hour Emergency Backup Plan, you have identified 3 levels of support for you to contact to ensure that those services and supports that are necessary to keep you safe are taken care of in emergency situations.

You will activate your 24-Hour Emergency Backup Plan when a service or support is not provided at a time that is critical to your safety and wellbeing.

First Level of Support—Your Own Backup System:

First, you will call your own backup system. This includes people such as friends and family members. Your Emergency Backup Plan will list their names and telephone numbers. If you are unable to reach these people, after several attempts of calling, or if they are unable to assist you, then you will move to the 2nd level of support identified on your plan.

Second Level of Support—Your Service Provider(s):

Your next step will be to call the agency or agencies that are identified on your Emergency Backup Plan. This agency may be the agency scheduled to provide the service or another agency that is able to provide the needed service or support. Your Emergency Backup Plan will list these agencies' names and telephone numbers. If you are unable to reach these people after several attempts of calling, or if they are unable to assist you, then you will move to the 3rd level of support identified on your plan.

Third Level of Support—Alliance for Better Long Term Care:

If your own backup system and your service/support provider are not able to assist you, you will call the Alliance for Better Long Term Care. The Alliance for Better Long Term Care will provide emergency backup support to all MFP participants, should a breakdown occur in the first two levels of support.

In order to better assist you, the Alliance will ask you some questions about the calls you made to your first two layers of support and other questions that will enable them to better assist you. As a follow up to your call, the Alliance will also let your Transition Coordinator know what happened. Your Transition Coordinator will then contact you to follow up and review your Emergency Backup Plan to see if any changes should be made.

Critical Incident Reporting Fact Sheet

Completed By	
Program	RTH
Signed by Individual	NO

This is another fact sheet, to be left with the individual. This fact sheet is for RTH individuals. It describes types of reportable incidents and the process for reporting.

Critical Incident Reporting Fact Sheet

How to recognize Abuse, Neglect and Exploitation:

Abuse: Abuse can be any action that harms or threatens your physical or emotional health or welfare. For example, physical abuse could include hitting you, shoving or shaking you, slapping or kicking you. Sexual abuse could include unwanted touching and emotional abuse could include if someone verbally assaults you or intimidates you.

Neglect: Neglect is when a caregiver does not give you the things you need to be healthy and safe like food or medicine. It is also neglect when a caregiver does not report changes in your health or doesn't try to protect you from abuse, neglect or exploitation by others. For example, it is neglect if a caregiver does not tell your doctor or nurse that you have fallen or been hurt.

Self-neglect: Self-neglect is when you fail to provide adequate care to yourself. For example, it may be self-neglect if you are living in hazardous, unsafe or unsanitary conditions or refuse or fail to provide yourself with an adequate supply of food or water.

Exploitation: Exploitation is when someone uses your money or property without your permission. For example, someone who illegally withdraws money out of your account or forges one of your checks or steals things from you is exploiting you.

How to Report Abuse , Neglect or Exploitation:

If you feel that you have experienced any of the above situations, you should contact:

- If you are 60 years old or older you will call the Department of Elderly Affairs (DEA) Protective Services at **(401) 462-0555**.
- If you are under 60 years old and disabled, you will call the Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH) at **(401) 462-2629**.

Reporting all other Critical Incidents: CALL (401) 533-0506

The Alliance for Better Long Term Care is available 24 hours a day, 7 days a week, to receive calls from **you or your caregiver** should any of the following situations occur. Reports should be made within 24 hours of the situation occurring.

- You went to the hospital, either planned or unplanned.
- You went to the emergency room for any reason.
- You had to deal with the police for any reason.
- You have suddenly disappeared and no one knows where you are.
- You had to leave your home because of a disaster, like a fire or flood.

As a follow up to your call to the Alliance, the Alliance will contact your Transition Coordinator who will then follow up with you to review your care plan and make sure it still meets your needs.

DHS/DEA Notification of Recipient Choice (CP12)

Completed By	RN
Program	NHTP and RTH
Signed by Individual	YES

This form is completed by the nurse and is signed by the individual at the initial assessment. It serves as the record that the individual has been notified that they have a choice regarding whether or not to stay in the nursing home. This form is required for both NHTP and RTH individuals.

**RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
RHODE ISLAND DEPARTMENT OF ELDERLY AFFAIRS (CP12A)**

NOTIFICATION OF RECIPIENT CHOICE

Date _____

Recipient Name _____

Address _____
Name of facility if applicable

Street

City/Town Zip Code

Social Security Number _____

Recipient Notification

I understand that I have been assessed and found to require the services provided in a Nursing Facility. I have now been offered a choice between community-based care or patient care in a Nursing Facility.

I have chosen:

- _____ Continued placement in a Nursing Facility
- _____ Remain in community and receive in-home care which may include Home Health Aide services, Homemaker services, minor assistive devices, minor modifications to the home and other Medical Assistance Program covered services through a Medicare Waiver Program.
- _____ Receive services in an Assisted Living Facility.
- _____ Receive services of the PACE Program.
- _____ Receive Services of the Shared Living Program
- _____ Receive Services of the Personal Choice Program

Signature of Recipient or Representative

Post-Assessment Status Form

Completed By	RN
Program	NHTP and RTH
Signed by Individual	NO

This form is completed by OCP/RTH nurse once the assessment has been completed. This form records whether the individual is appropriate to transition, not appropriate to transition at this time, or a decision regarding transition has not yet been made. The data from this form trigger a person's status being changed in the Access database from New Referral to either **Active/Waiting**, **Active/Waiting Community Placement**, or **Not a Candidate**. This form also records the date an individual signed the RTH Consent Form or declined participation. There is a comment field for each section. The OCP/RTH nurse should provide detailed notes regarding the transition decision. These comments will be entered into the Access database and will appear on the Nursing Home Operations Report. If the OCP/RTH nurse indicates that the individual is not a candidate for transition, they must select one of the reasons listed on the form. This form is required for both NHTP and RTH individuals.

Client Name: _____ Today's Date: ___/___/___
Date CTA completed: ___/___/___ Date CMA completed: ___/___/___

A. Individual is appropriate to transition

- Individual has housing
 - Individual needs housing: ___ housing list ___ group home ___ ALR ___ shared living
- Please provide detailed comments: _____
- _____

For MFP:

Client consented _____ Date _____ Client declined participation _____ Date _____

If client chose not to participate, please provide the reason: _____

Were there any issues obtaining informed consent? Yes No

If yes, what were the issues?

- Ensuring informed consent Involving guardians in transition planning
- Communication or frequency of communication with guardians
- Involving guardians in ongoing care planning Training and mentoring of guardians
- Other: _____

B. Individual is not a candidate for transition

- Reason:
- Left NH prior to eligibility MA denied
 - Patient refused to pay share Patient chooses to stay in NH
 - Determined unsafe transition Patient refused services
 - Worsening medical condition Not appropriate for program

Comments: _____

C. Decision regarding transition has not yet been made

Comments: _____

If you select "C", please complete this form again at a future date when the decision has been made.

Signature Date

Please submit this form to the MFP Project Office for data entry.

Informed Consent Form

Completed By	RN
Program	RTH only
Signed by Individual	YES

This form is signed by the RN and the individual or the individual's guardian/representative. The form is the written record of the discussion the nurse had with the individual outlining the RTH project, eligibility requirements, duration of the individual's participation, reasons for disenrollment and how the individual can register a complaint or withdraw from the program.

The Informed Consent Form should be carefully reviewed with the individual, and both the individual and the nurse should sign the form. Each case record will include two copies of the form—both should be signed by the individual and both should also be signed by the nurse. One copy should be left with the individual, and one should go into the case record.

In cases where the individual has a guardian or representative, that person may sign on behalf of the individual.

After the Informed Consent has been signed, please indicate the date it was signed on the Post-Assessment Status Form. This date will be entered into the Access database and will flag someone as RTH for all reporting and tracking.

This form is completed for RTH individuals only.

NAME:

SSN:



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Executive Office of Health and Human Services

**INFORMED CONSENT FOR PARTICIPATION IN THE
RHODE TO HOME
MONEY FOLLOWS THE PERSON DEMONSTRATION PROJECT**

- I have a desire to receive my services in a community-based setting rather than in the nursing home.
- I have received information regarding the Rhode to Home program (RTH).
- I have received information and understand the purpose and benefits of the RTH program.
- I understand this program is voluntary and choosing not to take part will not affect my eligibility for Medicaid or home and community-based services.
- I understand that I may have a monthly contribution towards the cost of any services.
- I understand that I currently qualify for the RTH program because: 1) I have resided in a nursing home for more than 90 days, 2) I am eligible for Medicaid, 3) my current medical needs can be met in the community at this time, and 4) I intend to move into a RTH qualified residence. I understand that if any of these conditions change prior to my discharge date, that I may be dis-enrolled from the RTH program, but I do understand that I may pursue community options in the future.
- I understand that by enrolling in this program I will :
 - be an active member in the development, implementation and monitoring of a service plan that is designed specifically for me,
 - have a Transition Coordinator assigned to me who will:
 - assist in the development, implementation and monitoring of my service plan,
 - assist me in moving from where I live now into a qualified RTH residence,
 - ensure that services that I am eligible to receive have been arranged for,
 - check in with me to ensure that the service plan is working and meeting my needs.
 - be eligible for demonstration services, provided through the RTH demonstration program that will include:
 - a Transition Coordinator for 365 days,
 - an emergency backup system which will be available to me 24 hours a day, 7 days a week, and
 - an agency contact to which I can report critical incidents.
- I understand that my participation in this RTH demonstration program is for 365 days. After the 365th day, I may continue to receive qualified home and community-based services as long as I remain eligible for Rhode Island Medicaid Long Term Care. If I do not meet the eligibility requirements for Long Term Care, I may be eligible for other services which my Transition Coordinator will describe for me and will assist me in obtaining.

NAME:

SSN:

QUALITY OF LIFE SURVEY

- I understand that I will receive the opportunity to answer survey questions about my housing, access to care, community involvement, my health and overall well-being.
- I understand that the results of this survey will help the state evaluate how well this program is meeting the needs of individuals like me.
- I understand that this survey will be conducted by an independent evaluator on three separate occasions: 1) before I leave the nursing home, 2) 11 months after I have transitioned from the nursing home, and 3) 24 months after I have transitioned from the nursing home.

PRIVACY

- I have been informed that information about me will be shared with the federal Centers for Medicare and Medicaid Services (CMS) and Mathematica Policy Research, a contractor for CMS, to evaluate the MFP program nationwide. My information will be confidential and will be protected under HIPAA, the Health Insurance Portability and Accountability Act.

LEAVING THE RHODE TO HOME PROGRAM

- I understand that my participation in the program is voluntary and that at any point I can choose to withdraw from the program.
- I understand that withdrawing from the program will not affect my eligibility for other Medicaid and home and community-based services. I can obtain a withdrawal form from my Transition Coordinator at any time.

EMERGENCY CONTACT INFORMATION

- I understand that I will be involved in developing an emergency backup plan that I can use in emergency situations.
- I understand that I can also contact my Transition Coordinator for non-emergency situations or if I feel that services are not meeting my needs or if my equipment breaks.

COMPLAINTS

- If I have any complaints or concerns about my participation in the RTH program I can contact my Transition Coordinator or the RTH Project Office at 401-462-1841.
- I have been informed that I may file a grievance or appeal of a decision. The Transition Coordinator has explained to me how to file a grievance or appeal. I have a written summary of how to start the process.

NAME:

SSN:

CONSENT

I have been fully informed about participation in the RTH program. My Transition Coordinator has explained to me my rights and responsibilities under this program. My signature, or the signature of a family representative, guardian or advocate, if applicable, indicates full consent to participate in the RTH program.

I understand that I will receive a signed copy of this consent to keep. If I have questions about the RTH program that cannot be answered by my Transition Coordinator I can call the RTH project office at 401-462-1841.

SIGNATURE – Participant	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number ()
SIGNATURE – Legal Guardian (if applicable)	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number ()
RHODE TO HOME STAFF ACKNOWLEDGEMENT I have read the informed consent materials to the applicant, and I believe that he/she (or the guardian, if signed) understands the materials.	
SIGNATURE – Transition Coordinator	Date Signed
Name – Agency	Telephone Number ()

OPTION TO FORMALLY DECLINE PARTICIPATION	
I was offered the opportunity to participate in the RTH demonstration project and have chosen to decline . I understand that this will not affect my eligibility for Medicaid or home and community-based services.	
SIGNATURE – Participant	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number () -
SIGNATURE – Legal Guardian (if applicable)	Date Signed
Address (Street, City, State, Zip Code)	Telephone Number () -

Quality of Life Survey Referral Form

Completed By	RN
Program	RTH
Signed by Individual	NO

This form is completed by the Nurse. It is then given to the designated staff, who follows up directly with the individual to schedule the baseline Quality of Life Survey. The Nurse or Transition Coordinator should inform the designated staff of the Quality of Life Survey once a transition date has been set. The individual should indicate if they are willing or refusing to participate in the Quality of Life Survey, which will take place prior to the individual transitioning to the community, approximately 11 months after they have transitioned, and then again approximately 24 months after they have transitioned. This form is only required for RTH individuals.

Rhode to Home (RTH) Quality of Life Survey Referral

.....

Client Name: _____

SSN: _____

Current Placement: _____

Address: _____

Telephone Number: _____

Placement Contact: _____

Discharge Date: _____
(Actual or Projected)

Did the Client refuse to take part in the QOL survey? Yes or No
If Yes, date member refused: _____

Is Client mentally competent to complete survey or is proxy needed?

Additional Information: _____

Signature of Transitional Coordinator

Today's Date

Quality of Life Survey Tracking Form

Completed By	Designated Staff
Program	RTH
Signed by Individual	NO

This form is completed by a designated staff. This form captures every time a Quality of Life Survey was attempted or completed.

If they individual initially refuses the baseline Quality of Life Survey, they should be invited to participate again after two weeks.

When attempting to reach the individual for the 11- and 24-month follow up surveys, up to 15 attempts at calling should be made. The attempts should be made on different days of the week and at different times of the day, to maximize the chances of reaching the individual. This form is only required for RTH individuals.

MFP Quality of Life Survey Tracking Form

This form needs to be completed whenever an MFP Quality of Life survey has been completed, or was due to be completed, but was not completed.

Client Name: _____

Timeframe: Baseline 11mo 24mo

Date QoL Survey administered: ____/____/____

Administered by: _____

Date survey data entry completed: ____/____/____

If the survey could not be completed, please select the reason:

Client refused

List the date of each attempt. Clients who initially refuse should not be contacted for 2 weeks.

Date of 1st attempt ____/____/____ Date of 2nd attempt ____/____/____

Missed

List date and time of all attempts. Attempts should be made at different times and on different days. Up to 15 attempts should be made.

Date	Time	Date	Time

Lost to follow up (died, move out of state)

Please submit to the MFP Project Office for data entry.

Provider Medical Statement (PM-1)

Completed By	PCP
Program	NHTP/RTH
Signed by Individual	NO

This form is completed by the individual's primary care physician whenever a Level of Care determination is due.



Medical Evaluation of Applicant For Level of Care For Admission To A Skilled Nursing Facility, Assisted Living or Community Based Services

Instructions To The Examining Provider

As the examining provider (MD, DO, RNP, PA), you will be assessing the patient's Functional Activities and Medical Diagnosis/Treatment using the following forms. Note: it must represent the patient's CURRENT condition. Please include dates.

The patient listed below has requested that the Office of Health and Human Services (OHHS) obtain this medical evaluation form from you as a basis for application. You are requested to complete this form in detail so that the Office of Medical Review (OMR) within OHHS can determine the level of care.

Code Key

Key indicates the patient's ability to care for self during a 24 hour period (over the last seven days). (for use on page 3)

0 = Independent – No help or oversight – **OR** – help/oversight provided only 1 or 2 times during the last seven days

1 = Supervision – Oversight, encouragement or cueing provided 3 or more times – **OR** – Supervision (3 or more times) plus limited physical assistance provided only 1 or 2 times during the last seven days.

2 = Limited Assistance – Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times – **OR** – Limited assistance (3 or more times) plus extensive assistance provided only 1 or 2 times in the last seven days.

3 = Extensive Assistance – While individual performed part of activity, weight-bearing support or full caregiver performance 3 or more times over part (but not all) of the last seven days.

4 = Total Dependence – Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would **NOT** be coded as a "4" Total Dependence.

5 = Activity did not occur

Housing Preferences and Referral Form

Completed By	TC/SW/RN
Program	NHTP/RTH
Signed by Individual	NO

This form is completed by the Transition Coordinator/Social Worker or Nurse after interviewing the individual and is given to the Housing Coordinator. Some of the elements needed for the referral are gathered during the assessment process, as they require individual input. Other elements may be completed after the assessments have been done. The form outlines individual preferences for location, and type of housing, as well as the Transition Coordinator/Social Worker/Nurse's recommendations. It also includes a number of elements helpful to the Housing Coordinator as she searches for available apartments, public housing or Assisted Living residences.

When the Transition Coordinator/Social Worker submits this form to the Housing Coordinator, she or he should also provide the complete case record. The Housing Coordinator will hold onto the entire case record until she has secured housing or until she receives information from a Nursing Home that an individual's health status may have changed, possibly affecting their appropriateness for transition. In such cases, the Housing Coordinator will refer the case back to the Transition Coordinator/Social Worker or Nurse for clinical follow up. This form is required for both NHTP and RTH individuals.

NHTP Team RN: _____ SW: _____
 MFP or NHTP

- AL Waiver
- AL SSI
- Housing

Housing Preferences and Referral Form

Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F		Date: / /
Facility: _____	Phone: -	SCW: _____
SSN: - -	DOB: / /	Marital Status: _____

Do you have a preference on geographic area? Yes No

If yes, which towns would you prefer?

<input type="checkbox"/> Barrington	<input type="checkbox"/> E. Greenwich	<input type="checkbox"/> Lincoln	<input type="checkbox"/> Pawtucket	<input type="checkbox"/> Warren
<input type="checkbox"/> Bristol	<input type="checkbox"/> E. Providence	<input type="checkbox"/> L. Compton	<input type="checkbox"/> Portsmouth	<input type="checkbox"/> Warwick
<input type="checkbox"/> Burrillville	<input type="checkbox"/> Exeter	<input type="checkbox"/> Middletown	<input type="checkbox"/> Providence	<input type="checkbox"/> W. Greenwich
<input type="checkbox"/> Central Falls	<input type="checkbox"/> Foster	<input type="checkbox"/> Narragansett	<input type="checkbox"/> Richmond	<input type="checkbox"/> W. Warwick
<input type="checkbox"/> Charlestown	<input type="checkbox"/> Gloucester	<input type="checkbox"/> Newport	<input type="checkbox"/> Scituate	<input type="checkbox"/> Westerly
<input type="checkbox"/> Coventry	<input type="checkbox"/> Hopkinton	<input type="checkbox"/> N. Kingstown	<input type="checkbox"/> Smithfield	<input type="checkbox"/> Woonsocket
<input type="checkbox"/> Cranston	<input type="checkbox"/> Jamestown	<input type="checkbox"/> N. Providence	<input type="checkbox"/> S. Kingstown	
<input type="checkbox"/> Cumberland	<input type="checkbox"/> Johnston	<input type="checkbox"/> N. Smithfield	<input type="checkbox"/> Tiverton	

Are you a veteran? <input type="checkbox"/> Y <input type="checkbox"/> N		Do you smoke? <input type="checkbox"/> Y <input type="checkbox"/> N		Require oxygen? <input type="checkbox"/> Y <input type="checkbox"/> N	
Do you have family support? <input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____					
Do you have pets? <input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____					
Do you have a criminal record? <input type="checkbox"/> Y <input type="checkbox"/> N Explain: _____					
Have you ever lived in public housing? <input type="checkbox"/> Y <input type="checkbox"/> N			Have you ever been evicted? <input type="checkbox"/> Y <input type="checkbox"/> N		
If yes, why? _____					
Have you applied anywhere? <input type="checkbox"/> Y <input type="checkbox"/> N Where and when? _____					
Do you use a <input type="checkbox"/> walker <input type="checkbox"/> cane <input type="checkbox"/> wheelchair?			Can you climb stairs? <input type="checkbox"/> Y <input type="checkbox"/> N		
If yes, how many flights? _____					
Do you need a handicap accessible apartment? <input type="checkbox"/> Y <input type="checkbox"/> N		Do you need public transportation? <input type="checkbox"/> Y <input type="checkbox"/> N		Do you need:	
				<input type="checkbox"/> Furniture	
				<input type="checkbox"/> Clothes	
				<input type="checkbox"/> Household supplies	
				<input type="checkbox"/> Food?	

Income \$ _____ per _____

Resources \$ _____

Has: Birth Certificate Social Security Card License/ID

Health Insurance: _____ LTC COMM MA SSI MPP

Housing Progress Update Form

Completed By	Housing Specialist
Program	NHTP and RTH
Signed by Individual	NO

This form is completed by the Housing Specialist at least monthly on each individual waiting for housing. The form captures the progress the Housing Coordinator has made towards securing housing for the individual and outlines the specific activities that have been completed towards that goal. This form is required for both NHTP and RTH individuals.

**NURSING HOME TRANSITION
HOUSING PROGRESS UPDATE**

Client Name: _____ Date: _____

NHTP MFP

Please complete this form within the first 30 days after the case has been assigned to the Housing Coordinator and then at least monthly thereafter.

What progress has been made towards the client's transition since the last Progress Update?

- Obtaining needed verification for housing applications
- Assistance with filling out housing applications
- Calls regarding housing
- Viewed apartment(s)
- Follow-up with Nursing Home regarding health status
- Other: _____

Please describe progress in detail:

Please select the reason the case is being returned to the Transition Coordinator:

Housing has been obtained Name of housing: _____
Date available: ____/____/____

Nursing home has indicated that client's medical or mental status has declined and the client may no longer be appropriate for transition. Please follow-up with Nursing Home and client to make a determination on whether to keep this case open.

Date case returned to Transition Coordinator: ____/____/____

Signature

Date

Please submit to the MFP Project Office for data entry.

Transition Pending Progress Update

Completed By	TC/SW
Program	NHTP/RTH
Signed by Individual	NO

This form is completed by the Transition Coordinator/Social Worker. It should initially be completed within 30 days after the assessment have been completed and then at least monthly thereafter. This form is required for both NHTP and RTH individuals.

NURSING HOME TRANSITION PENDING PROGRESS UPDATE

Please complete the front of this sheet for all individuals in NHTP or MFP.

Please complete the back only for MFP.

Client Name: _____ Date: _____

Please complete this form within the first 30 days after the CTA and CMA have been completed and then at least monthly thereafter.

Transition Pending

Reason:

- Housing not available
 Home modifications not yet complete
 Adaptive technology not yet in place
 Services not yet in place. Describe: _____

- NH stay has been extended due to medical reasons
 LTC Medicaid eligibility pending
 LTC Medicaid eligibility denied—appeal pending
 Other: _____

What progress has been made towards the client's transition since the last Progress Update?

- Calls regarding housing
 Assistance with filling out housing applications
 Follow-up with Nursing Home regarding health status
 Follow-up with providers regarding home based services
 Other: _____

Please describe progress in detail: _____

If transition is no longer possible, please select a reason and provide a comment.

This will change their database status to "Not a candidate." This should be filled out for NHTP and MFP individuals.

- | | |
|---|--|
| <input type="checkbox"/> Left NH prior to eligibility | <input type="checkbox"/> MA denied |
| <input type="checkbox"/> Patient refused to pay share | <input type="checkbox"/> Patient chooses to stay in NH |
| <input type="checkbox"/> Determined unsafe transition | <input type="checkbox"/> Patient refused services |
| <input type="checkbox"/> Worsening medical condition | <input type="checkbox"/> Not appropriate for program |

Comment: _____

OVER→

Additional question on back for MFP individuals.

Please submit to the MFP Project Office for data entry.

For MFP clients only:

Please select an MFP-specific reason and complete the MFP Disenrollment/Unable to Transition Form. If none of the listed reasons apply, please select "Other" and provide a comment. These categories are required for CMS reporting.

Reason:

Individual's physical health, mental health, or other service needs or estimated costs were greater than what could be accommodated in the community or through the state's current waiver programs.

Individual chose a type of residence that does not meet the definition of MFP qualified residences.

Individual changed his/her mind about transitioning, did not cooperate in the planning process, had unrealistic expectations, or preferred to remain in the institution.

Individual's family member or guardian refused to grant permission, or would not provide back-up support.

Other: _____

Signature

Date

Please submit to the MFP Project Office for data entry.

Qualified Residence and Home Safety Evaluation

Completed By	TC
Program	RTH
Signed by Individual	NO

This evaluation will be completed by the Transition Coordinator, who will evaluate the intended residence in person to be sure it meets the requirements as RTH-qualified housing.

**MFP- THE RHODE TO HOME
 HOUSING ASSESSMENT
 QUALIFIED RESIDENCE AND HOME SAFETY EVALUATION**

Living Arrangement	Yes	No
HOUSE, APARTMENT, OR ASSISTED LIVING		
<p>Is the dwelling owned/leased by client or family member and in that individual's name?</p> <p>Do you share the home with another individual?</p> <p>(if yes) Is the dwelling <u>rented</u> or <u>sublet</u> to another person while the client maintains full ownership of the property? (or) Is the dwelling <u>co-owned</u> or <u>co-leased</u> with another individual? <i>Please circle one of the underlined choices above</i></p> <p>Do all parties in the home maintain independent or equal rights to enforcement of the lease and/or ownership of responsibilities?</p> <p>Does the dwelling have two ways to enter or exit with lockable doors?</p> <p>Does the dwelling have living, sleeping, bathing and cooking space that is solely used and accessible to the client/family?(Refrigerator, microwave, countertop space, sink and stove)</p> <p>Does your dwelling's lease/rental agreement comply with federal fair housing requirements? <i>Please see below</i></p> <p><i>The lease should not include</i></p> <ul style="list-style-type: none"> • <i>Rules and/or regulation from a service agency as conditions of tenancy or include a requirement to receive services from a specified company.</i> • <i>Required notification of absence periods.</i> • <i>Provisions for being admitted, discharged, or transferred out of or into a facility.</i> • <i>Reserving the right to assign apartments and change apartment assignments.</i> 		
<u>ASSISTED LIVING ONLY</u>		
<p>Is the living arrangement an individual apartment unit?</p> <p>If client is sharing an apartment, was this decision voluntary?</p>		
RESIDENTIAL PROGRAM		
Does the dwelling have two ways to enter or exit with lockable doors?		

**MFP- THE RHODE TO HOME
HOUSING ASSESSMENT
QUALIFIED RESIDENCE AND HOME SAFETY EVALUATION**

Are there more than 4 unrelated individuals residing in the same living space? (not including care givers or personal attendants)		
Is the dwelling part of a larger congregate care setting (campus)?		
Is the dwelling separate (isolated) from the community building?		
Is the residence owned and operated by a person or organization other than the individual?		

Home Safety Checklist:

Throughout your Residence	Yes	No	N/A
<ol style="list-style-type: none"> 1. Can you turn on a light without having to walk into a dark room? 2. Are passageways in all rooms free from objects, clutter and cords? 3. Are curtains and furniture at least 12 inches from baseboards or portable heaters? 4. Do all carpets, scatter rugs and runners lie flat and stay put? 5. Are there working smoke detectors in all rooms and passageways? 6. Are all rooms and passageways wheelchair accessible? 7. Is there an emergency exit plan in case of fire? 8. Are there any chairs on wheels that could pose a hazard? 9. Is there a working flashlight in case of a power outage? 10. Do you have emergency phone numbers listed by every phone? 11. Are there telephones located in at least 2 rooms? 			
Kitchen			
<ol style="list-style-type: none"> 1. Are your stove controls easy to use and see? 2. Do you keep loose fitting clothing, towels and curtains away from burners and the oven? 3. Is there a working fire extinguisher available? 4. Can you reach regularly items without climbing to reach them? 5. Do you have a reliable step stool? 			
Bedrooms			
<ol style="list-style-type: none"> 1. If available, are pull cords visible and accessible? 2. Is there enough room to maneuver around the bed? 3. Are there safety rails on the bed? 			

**MFP- THE RHODE TO HOME
HOUSING ASSESSMENT
QUALIFIED RESIDENCE AND HOME SAFETY EVALUATION**

4. If available, is the commode placed close to the bed against a wall? 5. Is a phone and light switch/lamp within reach of your 6. bed? 7. Is a light left on at night between your bed and the toilet?			
Bathroom			
1. If available, are pull cords visible and accessible? 2. Is a shower or transfer bench in place? 3. Does the tub/shower have a sturdy grab bar? 4. Is the hot water temperature 120 degrees or lower? 5. Are you able to transfer on and off of the toilet? 6. Does your shower or tub have non-skid surface?			
Stairways			
1. Do you have access to an elevator? (if so move on to next section) 2. Is a light-switch at the top and bottom of each inside staircase? 3. With the light on, can you clearly see the outline of each step as you go down the stairways? 4. Do all of your stairways have sturdy hand rails on both sides that run the length of the stairway? 5. Are all steps in good repair?			
Front and Back Entrances			
1. Are all entrances well lit? 2. Are all door locks in proper working condition? 3. Are all outdoor entryways free from cracks and holes?			

Making Your Home Safer

What home safety changes do you suggest?

1. _____
2. _____
3. _____

Signature of Transition Coordinator

Date

Signature of Client

Date

Nursing Home Transition Case Management Cover Sheet

Completed By	TC/SW
Program	NHTP/RTH
Signed by Individual	NO

This form has not yet been finalized, but will be faxed to DEA or LTC at the time of transition. This form will notify these agencies of a pending referral for case management for either an NHTP or RTH individual. This form should be faxed on the day the individual is discharged from the Nursing Home.

Nursing Home Transition Referral to DEA and Nursing Home Transition Referral to LTC

Completed By	TC/SW
Program	NHTP/RTH
Signed by Individual	NO

This form is submitted to either DEA or LTC to ensure the process of case management transfer for both NHTP and RTH individuals. This form is faxed 30 days before the NHTP individual's participation ends or 30 days before the RTH individual's 365 participation days ends.



9/28/12

Nursing Home Transition Referral
Division of Elderly Affairs

DEA Case management Agency: _____ Fax #: _____

LTC Office/Worker: _____ Fax #: _____

Today's Date: _____ Date Faxed to LTC: _____

Client Name: _____ DOB: _____ SSN: _____

Home Address: _____ Apt#: _____ Floor: _____

City/Town: _____ Zip: _____ Phone: _____

Family/Other Contact: _____ Phone: _____ Relationship: _____

OCP Contact: _____ Phone: _____

Discharge Date: _____ NH Discharged from: _____

Program Needed: [] DEA/CORE [] DEA/ALF [] L [] F

Waiver Start Date: _____ DEA Case Management Start Date: _____

Assisted Living Residence Name: _____

[] WSF-I needed for submission to LTC unit within 30 days

Documentation:

Table with 3 columns: Document Name, Attached checkbox, In CSM checkbox. Rows include GW-SP, CMA, LOC, Calculator Tool, Nursing Summary, Medication Lists, CP-12, InRhodes Share/Unea. Panels, and Category D Assessment.

Select all appropriate:

Client is: [] NHTP [] MFP and will be followed by OCP for 30 days

[] Client has been deemed Medically Complex and will be followed by the OCP RN ongoing in the community
OCP RN: _____ Phone #: _____

[] Transition is not supported by the OCP team, please refer to Case Management Assessment for further details



Nursing Home Transition Referral Long Term Care

LTC Office/Worker: _____ Fax #: _____

Today's Date: _____

Client Name: _____ DOB: _____ SSN: _____

Home Address: _____ Apt#: _____ Floor: _____

City/Town: _____ Zip: _____ Phone: _____

Family/Other Contact: _____ Phone: _____ Relationship: _____

OCP Contact: _____ Phone: _____

Discharge Date: _____ NH Discharged from: _____

Program Needed: DHS/CORE DEA/CORE DEA/AL L F

Waiver Start Date: _____ LTC/DEA Case Management Start Date: _____

Assisted Living Residence Name: _____

Documentation:

GW-SP	<input type="checkbox"/>	Attached	<input type="checkbox"/>	In CSM
CMA	<input type="checkbox"/>	Attached	<input type="checkbox"/>	In CSM
LOC	<input type="checkbox"/>	Attached	<input type="checkbox"/>	In CSM
Calculator Tool	<input type="checkbox"/>	Attached		
Nursing Summary	<input type="checkbox"/>	Attached		
Medication Lists	<input type="checkbox"/>	Attached		
CP-12	<input type="checkbox"/>	Attached		

Select all appropriate:

Client is: NHTP MFP and will be followed by OCP for 30 days

Client will be referred to DEA for Case Management
Agency: _____ Phone #: _____

Client has been deemed Medically Complex and will be followed by the OCP RN ongoing in the community
OCP RN: _____ Phone #: _____

Transition is not supported by the OCP team, please refer to Case Management Assessment for further details

Transition Placement Form

Completed By	TC/SW
Program	NHTP/RTH
Signed by Individual	NO

This form is completed by the Transition Coordinator/Social Worker at the time the individual transitions to the community. It is very important that all the questions on this form be completed, as many of these data elements are reported to the State Senate and to CMS. In addition to the address and contact information of the individual transitioning, you must also record the name and phone number of an alternate contact person. This is necessary so that we may follow up with the individual for the RTH Quality of Life Survey. This form is required for both NHTP and RTH individuals.

TRANSITION PLACEMENT*To be completed at the time of NH discharge/transition home*

Client: NHTP or MFP Transition Date:

Transition Address: Phone:
(including city and zip)

Alternate Contact Person Name: Alternate Contact Person Phone:

1. Transition Placement:

- Home with CORE/DHS Home with CORE/DEA
 Assisted Living Shared Living
 MHRH Group Home
 Home with Personal Choice (*if client is going home on CORE but desires Personal Choice as soon as it becomes available, please select CORE and Personal Choice*)

- a. Is the individual hiring and supervising their own PAs or is a representative doing it for them?
 SELF REPRESENTATIVE
- b. Is the individual managing their own allowance/budget or is a representative doing it for them?
 SELF REPRESENTATIVE

*The following questions should be completed for MFP participants only:*2. What type of housing did the individual transition to? (*indicate with "X" below*)

<input type="checkbox"/> Home owned by participant	<input type="checkbox"/> Home owned by family member
<input type="checkbox"/> Leased Apartment, NOT assisted living	<input type="checkbox"/> Leased Apartment, assisted living
<input type="checkbox"/> Group home or other residence in which 4 or fewer unrelated individuals live	

3. Is the individual living with family members? YES NO4. Did individual receive a housing supplement? YES NO

↓ Select supplement category ↓ Select type

<input type="checkbox"/> Rent Restricted	<input type="checkbox"/> CDBG Funds	<input type="checkbox"/> HOME dollars	<input type="checkbox"/> Low income housing tax credits
<input type="checkbox"/> Supportive Housing	<input type="checkbox"/> CDBG Funds	<input type="checkbox"/> Low income housing tax credits	
<input type="checkbox"/> Public Housing Authorities	<input type="checkbox"/> CDBG Funds	<input type="checkbox"/> Housing choice vouchers	
<input type="checkbox"/> Private Homes	<input type="checkbox"/> Funds for home mods		
<input type="checkbox"/> Rhode Island Housing	<input type="checkbox"/> Funds for home mods		
<input type="checkbox"/> Deeply Subsidized	<input type="checkbox"/> Housing choice vouchers	<input type="checkbox"/> Section 811	
<input type="checkbox"/> Funds for assistive technology			
<input type="checkbox"/> Housing trust funds			
<input type="checkbox"/> Veterans Affairs housing funds			
<input type="checkbox"/> Other:			

Please submit to the MFP Project Office for data entry.

5. Were there any issues enrolling this individual? Yes No

If yes, what were the issues?

Determining initial eligibility

Other:

Signature of Transition Coordinator

Date

Combined Home Visit Progress Notes

Completed By	TC/SW/RN
Program	NHTP and RTH
Signed by Individual	NO

This form is completed by the Transition Coordinator/Social Worker or the Nurse. It serves as the outline for the weekly or monthly check-in call or visit the Transition Coordinator/Social Worker or the Nurse makes to the individual. Clinical staff may write their case notes on the bottom of this form or they may keep case notes separately. This form is required for both NHTP and RTH. Only one form should be completed and submitted if the OCP/RTH Nurse and Transition Coordinator/Social Worker perform a combined visit.

NHTP/MFP HOME VISIT PROGRESS NOTES

Client: _____ NHTP or MFP Date of visit/call: _____

Visit Type: Week 1 Week 2 Week 3 Week 4 2 month 3 month 4 month
 5 month 6 month 7 month 8 month 9 month 10 month 11 month Final Visit

Clinical Staff Member(s) performing this visit: _____

1. Where is the visit being performed: Client's Home Nursing Facility/Hospital

If SNF/Hospital,

Admission Date: _____

2. If visit is at home, have there been any Hospitalizations and/or Admits into SNF/Rehab Facilities since last contact:

No Yes Admission Date(s): _____ D/C Date(s): _____

Reason for Admission(s): _____

(If Admitted, please complete a critical incident form and a Suspension/Reactivation Form)

3. Have any of the following "critical incidents" occurred since last contact: Yes No

(If yes, indicate below and complete critical incident form)

- Abuse Neglect/Self-Neglect Exploitation Hospitalization ER Visit Involvement with criminal justice
 Medication administration error (that results in ER visit or hospitalization) Natural disaster (leads to displacement)
 Missing person Attempted suicide Death Other: _____

4. Have there been any changes/delays with the community based services provided since the Transition Plan/Last

"Check-in"? Yes No **(if yes, indicate below changes/delays)**

Services:	Start Date	Delay in start? (mark X)	Describe any changes made to frequency or duration.	Date of Change
Adult Day Center				
CNA				
DME				
ERS				
Homemaker				
Hospice Care				
Meals on Wheels				
Medication Cueing				
Mental Health Services				
Minor home mods				
Respite				
Senior Companion				
Skilled Services				
Complete at first visit only			↑ Complete at all visits week 2 and later ↑	

RTH Suspension/Reactivation Form

Completed By	TC/SW
Program	RTH
Signed by Individual	NO

The Suspension/Reactivation Form is the place to capture any breaks in community placement. This form captures the date of the suspension and the suspension reason, as well as the reactivation date.

The **suspension effective date** is the date the individual was admitted to a hospital, nursing home or psychiatric facility or the date the Transition Coordinator/Social Worker became aware that the individual left qualified housing, stopped following their treatment plan or enrolled in PACE. You will need to select one of following **reasons for suspension**:

- Hospitalization
- Re-admittance to a nursing home or psychiatric facility
- Left qualified housing
- Individual is not following their treatment plan
- Individual enrolled in PACE

If the reason for suspension was re-admittance to a nursing home or psychiatric facility, you will also need to select the **reason for admission** from the following list:

- Acute care hospitalization followed by long term rehab
- Deterioration in cognitive functioning
- Deterioration in health
- Deterioration in mental health
- Loss of housing
- Loss of personal caregiver
- By request of individual or guardian
- Lack of sufficient community services

The **reactivation effective date** is the date the individual returns to the community.

Please note: If the re-institutionalization is for longer than 30 days (31 or more days), a new plan of care is required.

If you are suspending an individual for a reason other than re-institutionalization, you will also need to complete and have the individual sign the **RTH Demonstration Program Suspension Form**. This form notifies the individual in writing that they are being suspended from participation in RTH, and the reason(s) why. This form informs the individual that they may be re-activated at a future date if the conditions surrounding the reason for suspension change. It also indicates that if circumstances do not change within a period of 6 months, that the individual will be permanently disenrolled from the program. This form is only required for MPF individuals.

MFP SUSPENSION/RE-ACTIVATION FORM

8.27.12

Client Name: _____ **Today's Date:** _____

Participants in MFP are eligible for 365 total days in the program. If an MFP participant is re-institutionalized (hospital, nursing home or psychiatric facility) for any period of time, their participation in MFP should be suspended. They should also be suspended if they leave qualified housing, do not follow treatment plan, or enroll in PACE. When this happens, the 365-day clock will stop. Once their suspension ends, the participant will be re-activated in MFP, and the 365-day clock will start again.

Please select which action you are taking (Select one only):

SUSPENSION **Effective date:** ____/____/____

Reason for suspension:

- Hospitalization
- Re-admittance to a NH or psychiatric facility

If re-admitted to NH or psychiatric facility, reason:

- Acute care hospitalization followed by long term rehab
- Deterioration in cognitive functioning
- Deterioration in health
- Deterioration in mental health
- Loss of housing
- Loss of personal caregiver
- By request of participant or guardian
- Lack of sufficient community services
- Left qualified housing
- Participant is not following their treatment plan
- Participant enrolled in PACE

REACTIVATION **Effective date:** ____/____/____

Reason for re-activation:

- Returned to community after hospitalization of up to 30 days
- Returned to community after hospitalization of greater than 30 days
- Re-entered qualified housing
- Following treatment plan again
- Disenrolled from PACE

Please note: if the re-institutionalization is for longer than 30 days (31 or more days), a new plan of care is required.

Signature

Date

Please submit to the MFP Project Office for data entry.

Critical Incident Form (External)

Completed By	Alliance Staff
Program	RTH
Signed by Individual	NO

Whenever a Critical Incident is reported to the Alliance, the Alliance staff will complete the Critical Incident Form (External). The Alliance is required to call the Transition Coordinator within 24 hours of learning of the incident and is required to fax this form within 48 hours of the incident. The Transition Coordinator should review the form and provide any needed follow-up and should document their activities in the Transition Coordinator section. The Transition Coordinator should then submit the form for review by the RTH Deputy Director.



**OFFICE OF COMMUNITY PROGRAMS
CRITICAL INCIDENT REPORT FORM for MFP PARTICIPANTS**

Section 1. General Information

Participant name:

Today's Date:

Date and time of incident: / / AM/PM :

Location of incident:

Name and Contact information of Person reporting incident:

Relationship of person reporting incident: Self Spouse Family member Neighbor Friend
 Home care provider Emergency Responder The Alliance Hospital Other state agency
 Choose not to identify Other

Section 2. Type of Incident

Type of event: Abuse Neglect/Self-Neglect Exploitation Hospitalization Death ER Visit
 Attempted Suicide Missing person Involvement with criminal justice system Medication
administration error (that results in an ER visit or hospitalization) Natural disaster (that leads to housing
displacement)

Section 3. Describe Incident and Cause

Section 4. Interventions and Outcomes

Names and roles of all involved in incident:

Names of witnesses to incident:

To be completed by MFP Transition Coordinator:

Describe Additional Follow-up Provided

Describe Corrective Action Taken to Prevent Future Incidents

Comment

Transition Coordinator Name: _____ Date: ___/___/___

Transition Coordinator Signature: _____

Date submitted to MFP office: ___/___/___

To Be Completed by the MFP Management Team:

Comments

MFP Review done by: _____ Date: ____/____/____

Critical Incident Form (Internal)

Completed By	TC/SW/RN
Program	NHTP/RTH
Signed by Individual	NO

This form should be filled out by the Transition Coordinator/Social Worker or Nurse whenever a Critical Incident occurs or discovered for individuals in NHTP or RTH. Please refer to the Critical Incident Reporting Guidelines and Critical Incident definitions. This form should be completed and given to the MFP office within 24 hours of the Transition Coordinator/Social Worker or Nurse being informed of the incident. The form will be reviewed by the RTH Deputy Director and any comments or additional follow-up needed will be recorded. This form is required for both RTH and NHTP.



7.13.12

Office of Community Programs
CRITICAL INCIDENT REPORT FORM--INTERNAL

A "Critical Incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a Money Follows the Person or NHTP participant.

Section 1. General Information

Participant name:

Today's Date:

Date and time of incident:

Location of incident:

Name and Contact Information of person reporting incident:

Section 2. Type of Incident (*check which incident(s) apply*)

- Abuse Neglect/Self-Neglect Exploitation Hospitalization ER Visit
 Involvement with criminal justice system
 Medication administration error (that results in ER visit or hospitalization)
 Natural disaster (that leads to housing displacement) Missing person Attempted Suicide
 Death Other: _____

Section 3. Describe Incident and Cause

Section 4. Interventions and Outcomes

Names and roles of all involved in incident:

Names of witnesses to incident:

Action taken, by whom, and outcome:

Police or other investigative authorities (Describe involvement, provide contact information and attach any reports):

Medical treatment provided to person involved in incident:

Facility or physician providing treatment:

Telephone number:

Section 5. Other Parties or Agencies Contacted

- | | |
|---|---|
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> HCBS Provider: _____ |
| <input type="checkbox"/> Guardian | <input type="checkbox"/> Police |
| <input type="checkbox"/> Family/Caregiver | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> DEA | <input type="checkbox"/> BHDDH |
| <input type="checkbox"/> PCP/health care practitioner | <input type="checkbox"/> The Alliance |
| <input type="checkbox"/> Other: _____ | |

Section 6. Describe Additional Follow-up Provided

Section 7. Describe Corrective Action Taken to Prevent Future Incidents

Section 8. Comments

Transition Coordinator Signature:

Date:

Date submitted to MFP Office: _____

***REMINDER: If a critical incident involves a hospitalization,
PLEASE COMPLETE A SUSPENSION/REACTIVATION FORM***

To Be Completed by the MFP Management Team:

Comments

Review done by: _____ Date: ____ / ____ / ____

24-hour Emergency Backup Usage Report

Completed By	Alliance Staff
Program	RTH
Signed by Individual	NO

This form is completed by Alliance staff and provides information on calls made by RTH individuals to the Alliance and emergency backup was provided. The Alliance will assist RTH individuals in getting the necessary services and supports in place as quickly as possible in order to ensure the individual's safety, in the event that their own two levels of backup have not been able to assist. This report will be faxed to the Transition Coordinator, who will then review the situation, follow up as needed, and document his/her follow up activities in the Transition Coordinator section. This form will then be submitted to the RTH Deputy Director for review.



**Rhode to Home
24-hour Emergency Back-up Usage Report**

Emergency Back-up is to be provided to Rhode to Home participants as a last resort if all other layers of support fail and the participant's safety, health or well-being would be at risk if a particular service/support is not otherwise provided.

Section 1. General Information

Participant Name:

Date and Time of Call: / / am/pm :

If participant left a message

Date and Time of Return Call: / / am/pm :

Section 2. Reason for the Call

What was the service/support that failed:

Name of Provider:

Reasons why 1st two layers of back-up failed:

Section 3. Resolution

Date and Time Emergency Back-up was provided: / / am/pm :

How was the situation resolved:

If a Medicaid provider was utilized please include the name:

Additional Comments:

Signature

I certify that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge.

Printed Name: _____ Signature: _____

Title: _____ Date: _____

Date and time MFP Transition Coordinator called: Phone 401-462-1841	Date ____ / ____ / ____ Time ____ : ____ am/pm
Date and time MFP Transition Coordinator faxed: Fax 401-462-4266	Date ____ / ____ / ____ Time ____ : ____ am/pm

To be completed by MFP Transition Coordinator:

Describe Additional Follow-up Provided

Describe Corrective Action Taken to Prevent Future Incidents

Comments

Transition Coordinator Name: _____ Date: ____/____/____

Transition Coordinator Signature: _____

Date submitted to MFP office: ____/____/____

Please indicate which category this Emergency back-up assistance refers to:

- Transportation to get to Medical appointment
- Life-support equipment repair/replacement
- Critical Health services
- Direct Service/support worker not showing up
- Other

To Be Completed by the MFP Management Team:

Comments

MFP Review done by: _____ Date: ____ / ____ / ____

Alliance Emergency Backup Activity Report

Completed By	Alliance Staff
Program	RTH
Signed by Individual	NO

On a monthly basis, the Alliance will submit to the RTH Deputy Director, a report of all the calls made to them by RTH individuals. This report will indicate the nature of the call, whether backup services or supports were in fact needed, and if so, what was done to resolve the situation. This report will be reviewed by the RTH Deputy Director and forwarded to the TC or nurse.

DEA Protective Services Referral Form

Completed By	TC/SW/RN
Program	NHTP/RTH
Signed by Individual	NO

If the Transition Coordinator/Social Worker or Nurse learns of any abuse, neglect, self-neglect or exploitation of an NHTP or RTH individual, they are required to report to DEA via this form.

State of Rhode Island
DEPARTMENT OF ELDERLY AFFAIRS
Protective Services Divisio



RIDEA
John o. Pastore Center
Hazard Building
74 West Road
Cranston, RI 02920

TO: _____ DATE: _____
AGENCY: _____
FAX #: _____

*In order to expedite the process of referrals to the RIDEA Protective Services Division, and enhance service delivery to vulnerable elders, the RIDEA Protective Services Division will accept fax referrals from Professionals (only). These fax referrals must be completed on the attached official **PROTECTIVE SERVICES REFERRAL FORM**. Referrals to the Protective Services Division must be appropriate to generate a departmental response to a situation of suspected elder abuse, neglect, exploitation or self neglect.*

****Please TYPE or PRINT (legibly)****

****Please include all necessary information and fill in all fields as completely as possible****

****Please provide a narrative of the specific concerns of suspected elder abuse, neglect, exploitation or self neglect (add another page if more room is needed)****

****If necessary, you may also attach documentation/reports to support your referral (e.g., police report)****

****Questions can be forwarded to our Intake Unit @ 462-0555****

RETURN TO: RIDEA PROTECTIVE SERVICES DIVISION
ATTN: INTAKE UNIT
FAX #462-0545

REMINDER:

Compliance with all departmental confidentiality rules and policies is required when faxing referrals.

R.I. Department of Elderly Affairs
PROTECTIVE SERVICES REFERRAL FORM

For Professional Use Only

PLEASE PRINT OR TYPE AND RETURN TO:

FAX #462-0545

DATE: _____

CLIENT INFORMATION

CLIENT NAME: _____ GENDER: [] Male [] Female
(last) (first) ETHNICITY: _____
ADDRESS: _____ [] Hispanic or Latino
APT. NAME: _____ [] Not Hispanic or Latino
APT.# or FLOOR: _____ [] Unknown
CITY/TOWN/ZIP: _____ Is client English speaking? [] Yes [] No
PHONE #: _____ If NO, what is primary language? _____
D.O.B.: _____ Is an Interpreter needed? [] Yes [] No
AGE: (must be 60 or over) _____ CLIENT
SS#: _____ CONTACTS: _____

***PLEASE NOTE THAT THE 9-DIGIT
SS# IS REQUIRED***

Is there evidence that the client has problems with Substance Abuse? [] Yes [] No
Is there evidence of any Potential Contagious Disease? [] Yes [] No

ALLEGED PERPETRATOR INFORMATION (if applicable)

Name of Person Responsible for Alleged Abuse/Neglect/Exploitation: _____
Relationship to Client: _____
Does He or She Reside With Client?: (please check) [] Yes [] No
If NO, Address: _____
Phone #: _____

Is there any evidence of alleged perpetrator Substance Abuse? [] Yes [] No
If reason for referral is criminal in nature, was Alleged Perpetrator charged? [] Yes [] No

REPORTER INFORMATION

YOUR NAME: _____ AGENCY: _____
TITLE: _____ PHONE: _____

*** Please note the your referral will be reviewed and a determination will be made upon review if the referral meets DEA Protective Service criteria. If further information is needed for said determination, we will contact you via telephone or fax. Thank you. ***

**PLEASE USE ATTACHED
2ND PAGE
FOR NARRATIVE**

Disenrollment/Unable to Transition Form

Completed By	TC/RN
Program	RTH
Signed by Individual	NO

This form is completed by the RN or TC. It should be completed any time an individual dies, voluntarily withdraws, or for some other reason disenrolls from RTH.

In addition, this form should be filled out whenever a person who has signed an RTH Informed Consent Form is unable to transition or choose non-RTH qualified housing.

The form is only required for RTH individuals.

MFP DISENROLLMENT/UNABLE TO TRANSITION FORM

Client Name: _____

Disenrollment Date: ___/___/_____

Disenrollment Reason: Participant died Date of death: ___/___/_____

Participant no longer needed services

Voluntary withdrawal

Other: _____

Unable to Transition

Signature

Date

Please submit to the MFP Project Office for data entry.

MFP Demonstration Program Suspension Form

Completed By	TC
Program	RTH
Signed by Individual	YES

This form is completed by the Transition Coordinator. It should be used whenever an RTH individual is suspended from the program, for any reason other than a hospitalization or readmission to a Nursing Home or psychiatric facility.

For example, a person might be suspended if they move out of their initial community placement to housing that does not meet the criteria of an RTH qualified residence, if the individual is not following the care plan developed for them by the clinical team, if they have chosen to enroll in PACE after being transitioned to the community or for some other reason.

This form notifies the individual the reason they are being suspended and informs them that if the circumstances leading to their suspension do not change within six months, that they will be disenrolled from the program. It must be signed by the Transition Coordinator and the individual. This form is required for MPF individuals only.



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services

74 West Road
 Hazard Bldg. #74
 Cranston, RI 02920

Money Follows the Person (MFP) Demonstration Program Suspension Form

Individual First Name		Date of Birth	
Individual Last Name		Medicaid ID #	

I understand that my participation in the Money Follows the Person Demonstration Project (MFP) is being temporarily suspended for the following reason(s):

- I have moved to housing that does not meet the MFP criteria as a "qualified residence."
- I am not following the Care Plan created for me by the MFP clinical team, which may affect my safety in the community.
- I have chosen to enroll in the PACE program.
- Other: _____

I further understand that if circumstances related to reason(s) listed above change, that I may be re-activated into the MFP Program at a future date. I understand that if circumstances do not change relative to my eligibility for MFP within a period of 6 months, I will be permanently disenrolled from the program.

I understand that my suspension from the program will not affect my eligibility for other Medicaid Home and Community Based Services

 Individual Name/ Legal Guardian/ Legal Authorized Rep

 Date

.....

 MFP Staff

 Date

Suspension Effective Date: _____

Please submit to the MFP Project Office for data entry.

Notification of Disenrollment

Completed By	TC/RN
Program	RTH
Signed by Individual	YES

This form is completed by the RN or TC. It is the written notification to an individual that they have been disenrolled from the RTH program. A individual can be disenrolled because they have chosen to stay in the Nursing Home or because they voluntarily withdraw from the program for another reason or because they no longer meet the eligibility requirements for being an RTH individual (e.g. they choose to transition to non-qualified housing or they are no longer medically appropriate to transition.) This form is required for RTH individuals only.

Disenrollment Effective Date: ___/___/_____

10.22.12



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services

74 West Road
Hazard Bldg. #74
Cranston, RI 02920

**Money Follows the Person (MFP) Demonstration Program
Notification of Disenrollment**

Individual First Name		Date of Birth	
Individual Last Name		Medicaid ID #	

I understand that my participation in the Money Follows the Person Demonstration Project (MFP) is ending for the following reason:

1. Voluntary disenrollment

I am voluntarily choosing to withdraw from the MFP Demonstration program. I understand that my disenrollment from the program will not affect my eligibility for other Medicaid Home and Community Based Services.

Disenrollment Reason:

- I have chosen to move to non-qualified housing
- Other. Please explain:

2. Involuntary disenrollment

My current medical needs can not be met in the community at this time . I understand that I may contact The Alliance for Better Long Term Care at 401-785-3340 or 888-351-0808 if I disagree with the decision.

Individual Name/ Legal Guardian/ Legal Authorized Rep

Date

.....

MFP Staff

Date

Please submit to the MFP Project Office for data entry.

NURSING HOME TRANSITION DATA FLOW

OCP receives referral for transition services (Referral Form)



Determine appropriateness for NHTP/MFP (Screening Form)



Team completes Comprehensive Transition Assessment and obtains MFP informed consent
(CTA, Consent Form and Consent Cover Sheet, Case File Checklist)
(Also photocopy and submit the Transition Recommendations section (page 10) of the CTA if MFP)



Client's transition is pending
(Transition Pending Progress Update)



Client transitions to the community
(Transition Placement Form)



Transitions via MFP
Monthly contact
(Home Visit Progress Notes)

Transitions via NHTP
Contact during first 30 days only
(Home Visit Progress Notes)

Critical Incident
(Critical Incident Report)

Withdrawal
(Withdrawal Form)

Critical Incident
(Critical Incident Report)

Re-institutionalization
(Suspension/Re-activation Form)



Please submit all completed forms to the MFP Data inbox in Jennifer Bergeron and Jennifer Reid's office.