NHT Outreach 8-17-10

(1320553225)
8/17/2010

1. APPROPRIATE COMPLETION OF FORM IS REQUIRED FOR PAYMENT

1.A. CONSUMER Identification

1. **DATE Transition Case Opened**

2. **FIRST Name**

3. **Middle INITIAL**

4. **LAST Name**

5. **Name SUFFIX (if applicable)**

6. **Social Security Number (SSN)**

7. **DATE of CURRENT Medicaid Enrollment (if applicable)**

8. **MEDICAID Number (if applicable)**

1.B. CONSUMER Demographics

1. **DATE of Birth (DOB)**

2. **GENDER**
   - ☐ Female
   - ☐ Male

3. **Current MARITAL Status**
   - ☐ Divorced
   - ☐ Legally Separated
   - ☐ Married
   - ☐ Single
   - ☐ Widowed
   - ☐ Other-Document in Notes
   - ☐ Unavailable

4. **Ethnicity**
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino
   - ☐ Unknown

5. **Race(s)**
   - ☐ American Indian/Native Alaskan
   - ☐ Asian
   - ☐ Black/African American
   - ☐ Native Hawaiian/Other Pacific Islander
   - ☐ Non-Minority (White, Non-Hispanic)
   - ☐ White-Hispanic
   - ☐ Other-Document in Notes
   - ☐ Unknown/Unavailable

2. NHT INFORMATION

2.A. GENERAL Information

1. **Date Consumer was admitted to the Nursing Facility**

2. **Does the Consumer have a scheduled discharge date?**
   - ☐ No
   - ☐ Yes

3. **If 2.A.2 is Yes, indicate scheduled discharge date**

4. **Enter any intake/referral comments**

5. **Identify source of the Consumer's referral for transition. If source is not listed, document Details in Notes.**
   - ☐ AAA
   - ☐ Family
   - ☐ Friend
   - ☐ Home Health Agency
   - ☐ Hospital
   - ☐ Independence Initiative
   - ☐ FDIS
   - ☐ Nursing Home/Rehab Facility (non Section Q related)
   - ☐ Section Q Referral
   - ☐ OBRA-Target/Specialized Services
   - ☐ OLTL Community Partner
   - ☐ Ombudsman
   - ☐ Physician
   - ☐ Self
   - ☐ Social Services Agency
   - ☐ Other-Document Details in Notes

6. **If Consumer has a Legal Guardian, select yes. Otherwise, SKIP this question.**
   - ☐ Yes-Document Guardian's Name and if s/he is Court Appointed in Notes

7. **If Consumer met the eligibility requirements, did the Consumer sign the MFP Informed Consent Form agreeing to participate in the Money Follows the Person (MFP) Demonstration Program?**
   - ☐ No-Document any reasons stated in Notes
   - ☐ Yes
   - ☐ Consumer was not offered the form-Document Details in Notes.

2.B. ADDRESS of NURSING FACILITY

1. **Nursing Facility COUNTY**

2. Nursing Facility's MA Provider Number

3. Nursing Facility Name (do not abbreviate any part of Name for reporting purposes)

4. Nursing Facility Address

5. Nursing Facility Town

6. Nursing Facility Zip Code

7. Nursing Facility Telephone Number

3. TRANSITION Information

3.A. TRANSITION DATA - Complete 3.A.2 only if the response to 3.A.1 is NO

1. Did the Consumer complete transition to the community?

- ☐ NO - Document in 3.A.2 the reasons Consumer did NOT transition
- ☐ YES - SKIP to 3.A.3 - DO NOT enter a response in 3.A.2

2. If 3.A.1 was NO, list the BARRIERS that PREVENTED the Consumer from transitioning and document details in Notes.
Additional Barriers SPECIFIC TO MFP Consumers are to be entered in 5.A.2.
DO NOT ENTER a response here if answer to 3.A.1 was YES.

- ☐ Cognitive impairment
- ☐ Consumer requested
- ☐ Consumer relocated out of service area
- ☐ Could not locate appropriate housing arrangement
- ☐ Could not secure affordable housing
- ☐ Death
- ☐ Funding
- ☐ Guardian refused participation
- ☐ Lack of Formal/Informal support
- ☐ Mental health issues
- ☐ Physical health issues
- ☐ Poor credit or lack of credit history
- ☐ Service needs greater then what could be adequately provided in the community.
- ☐ Unwilling to follow care plan
- ☐ Other-Document Details in Notes

3. If Consumer transitioned, enter date of transition.

4. Name of the person responsible for Consumer's transition plan.

5. Name of the Agency/Provider responsible for Consumer's transition plan.

6. PSA # or the Agency/Provider's Medicaid #

7. Telephone number of the person responsible for Consumer's transition plan.

8. Indicate the Waiver or HCBS Program to which the Consumer transitioned.

- ☐ Act 150 Attendant Care
- ☐ AIDS Waiver
- ☐ Consolidated Waiver
- ☐ COMMCARE Waiver
- ☐ FCSP-Family Caregiver Support Program
- ☐ LIFE-Living Independence for the Elderly
- ☐ Michael Dallas Waiver
- ☐ OBRA Waiver
- ☐ Attendant Care Waiver
- ☐ OPTIONS
- ☐ Independence Waiver
- ☐ Aging Waiver
- ☐ Other - Document in Notes

9. Was there intervention and assistance (in addition to the normal supports and activities performed by care managers) to remove identified barriers for the successful transition of this Consumer?

- ☐ No
- ☐ Yes-Document Support Intervention in Notes

10. Indicate ALL BARRIERS that were OVERCOME for the Consumer to safely transition to the community. If there are any additional Barriers not listed, select Other and document Barrier(s) with Details in Notes.

- ☐ Family Issues
- ☐ Home Modifications
- ☐ Housing
- ☐ Lack of Formal/Informal Support
- ☐ Lack of Funding
- ☐ Service Provider Availability
- ☐ Unaware of Services/Lack of Information
- ☐ Other-Document Details in Notes

3.B. RESIDENTIAL ADDRESS of where Consumer Transitioned - MUNICIPALITY is Required

1. COUNTY

2. RESIDENTIAL Street Address (include number of house, apartment, or room)

3. RESIDENTIAL StreetnAddress Second Line (if needed)

4. MUNICIPALITY (REQUIRED - Township, Boro, or City where the Consumer Votes, Pays Taxes, etc.)

5. RESIDENTIAL City or Town (Optional but must be located within the Residential Municipality)

6. RESIDENTIAL State

7. RESIDENTIAL Zip Code (Optional)

8. TELEPHONE Number

9. What was the outcome when Consumer was offered a VOTER REGISTRATION FORM?

- ☐ Consumer will submit completed Voter Registration Form
- ☐ AAA will submit completed Voter Registration Form
- ☐ Consumer declined-already registered to vote
- ☐ Consumer declined Voter Registration Form
- ☐ Not Applicable

3.C. Community SUPPORT Needs of Consumer

1. Did the Consumer require ongoing and necessary formal services in the community after transition to maintain independence in the community?

- ☐ No
- ☐ Yes-Document Details in Notes

2. Was there a need to access State Special NHT Funds to transition this Consumer?

- ☐ No
- ☐ Yes-Document Details in Notes

4. CLOSEOUT Information

4.A. Assistance in Locating HOUSING

1. Did the Consumer transition to existing housing?

- ☐ No
- ☐ Yes-Skip to 4.A.5

2. Did the Consumer need NHT assistance with locating housing?

- ☐ No
- ☐ Yes

3. How was housing located?

- ☐ Family
- ☐ Friend
- ☐ Housing Authority
- ☐ Newspaper
- ☐ PA Apartment Locator
- ☐ Regional Housing Coordinator Assistance (RHC)
- ☐ Other-Document Details in Notes

4. Date housing was secured

5. Indicate the TYPE of housing to which the Consumer transitioned.

- ☐ Apartment
- ☐ AL-Assisted Living
- ☐ DC-Domiciliary Care
- ☐ House
- ☐ PCH-Personal Care Home
- ☐ Subsidized Housing
- ☐ Other-Document Details in Notes
- ☐ Unavailable

6. LIVING ARRANGEMENT (Include in the "Lives Alone" category, Consumers who live in AL, Dom Care, or PCH, pay rent, and have NO ROOMATE.)

- ☐ Lives Alone
- ☐ Lives with Spouse Only
- ☐ Lives with child(ren) but not Spouse
- ☐ Lives with Other Family Member(s)
- ☐ Other-Document Details in Notes
- ☐ Don't Know

4.B. Home Modifications/Adaptations/Assistive Technology

1. Did the Consumer require any home modifications, adaptations, or assistive technology to transition?

- ☐ No
- ☐ Yes

2. Identify any of the following home modifications the Consumer needed to transition.

- ☐ Doorways widened
- ☐ Kitchen/bathroom modifications
- ☐ Ramp
- ☐ Stair Glide
- ☐ Walk-in Shower

3. List any other home modifications or assistive devices not identified in 4.B.2 that the Consumer needed to transition.

5. REQUIRED for Candidates of MONEY FOLLOWS the PERSON (MFP) Program

5.A. MFP Required Data

1. Did the Candidate enroll in the MFP Demonstration Program?

- ☐ No-Document Details in Notes
- ☐ Yes-Skip to 5.A.3

2. Select all barriers specific to the MFP Program that prevented the Candidate from enrolling in the MFP Program. These barriers are in addition to any barriers listed in 3.A.2.

- ☐ Candidate did not choose MFP qualified residence.
- ☐ No longer Medicaid eligible.
- ☐ No longer MA service program eligible.
- ☐ Reconsideration about Candidate's participation.

3. Indicate the type of qualified residence to which the Consumer transitioned.

- ☐ Apartment leased by Consumer, NOT an Assisted Living Facility
- ☐ Apartment leased by Consumer in an Assisted Living Facility
- ☐ Home owned by Consumer
- ☐ Home owned by family member
- ☐ Group home of no more than 4 people

4. Does Consumer live with family members?

- ☐ No
- ☐ Yes

5. Did the MFP participant receive a housing supplement during the reporting period?

- ☐ Yes
- ☐ No

6. Identify all housing supplements received by the MFP participant during the reporting period.

- ☐ Low Income Housing Tax Credits
- ☐ HOME Dollars
- ☐ CDBG Funds
- ☐ Housing Choice Vouchers
- ☐ Housing Trust Funds
- ☐ Section 811
- ☐ 202 Funds
- ☐ USDA Rural Housing Funds
- ☐ Veterans Affairs Housing Funds
- ☐ Funds for Home Modifications
- ☐ Funds for Assistive Technology As It Relates To Housing

7. Specify here if participant received any housing supplement other than one listed above.