pennsylvania
DEPARTMENT OF HUMAN SERVICES

Guidebook for the Nursing Home Transition Program

December 2016

DRAFT

This page intentionally left blank.

Table of Contents

Acronyms……..4
Background and Overview of the Nursing Home Transition Program 5
1. Overview of Nursing Home Transition Coordination Activities 9
2. Guiding Principles, Roles and Responsibilities 10
3. Nursing Home Transition Coordination Agency / Coordinator Qualifications 15
4. Nursing Home Transition Process.....19
5. Money Follows the Person..... 23
6. NHT Non-Waiver and Act 150 Eligible Individuals.....25
7. NHT Transition Service Coordination - W7337 - Waiver Eligible Individuals 28
8. Special Nursing Home Transition Funding 33
9. SAMS.....36
10. Training Information in LMS 38
11. NHT Outreach Form 39
12. Cross County Transitions 40
13. LIFE Program 41
14. Housing and Other Community Resources.....42
15. Legal Issues.....47
16. Protective Services 55
17. Nursing Facility Resident Rights.....56
Resources and Additional Contacts……59
APPENDIX A: NHT Program MFP Checklist
APPENDIX B: Sample Physician's Certification form
APPENDIX C: Home and Community-Based Services Eligibility form 1768
APPENDIX D: Freedom of Choice form
APPENDIX E: MFP Informed Consent form / Quality of Life Referral form
APPENDIX F: Individual Service Plan form
APPENDIX G: Funding Request form
APPENDIX H: Service Provider Choice form
APPENDIX I: PA IEB Referral form
APPENDIX J: SNHTF vs CTS chart
APPENDIX K: Service Coordination rate map
APPENDIX L: RHC map

Acronyms

AAA -	Area Agency on Aging
ADL -	Activities of Daily Living
APS -	Adult Protective Services
ADRC -	Aging and Disability Resource Centers
CAO -	County Assistance Office
CED -	Clinical Eligibility Determination
CMI -	Care Managed Instrument
CTS -	Community Transition Services
DHS -	Department of Human Services
DRA -	Deficit Reduction Act
FCSP -	Family Caregiver Support Program
FDIS -	Front Door Information System
HCBS -	Home and Community-Based Services
HCSIS -	Home and Community Services Information System
HIPAA -	Health Insurance Portability and Accountability Act
IADL -	Instrumental Activities of Daily Living
ICF/MR -	Intermediate Care Facility for Mental Retardation
IEB -	Independent Enrollment Broker
ISP -	Individual Service Plan
MDS -	Minimum Data Set
MFP -	Money Follows the Person
LIFE -	Living Independently for the Elderly
LTL -	Long-Term Living
LTSS -	Long-Term Support and Services
NF -	Nursing Facility
NHT -	Nursing Home Transition
NHTCA -	Nursing Home Transition Coordination Agency
NHTC -	Nursing Home Transition Coordinator
NFCE -	Nursing Facility Clinically Eligible
NFI -	Nursing Facility Ineligible
OAPSA -	Older Adult Protective Services Act
OLTL -	Office of Long-Term Living
PC -	Physician’s Certification
PDA -	Pennsylvania Department of Aging
PHFA -	Pennsylvania Housing Finance Agency
QoL -	Quality of Life
RHC -	Regional Housing Coordinator
SAMS -	Social Assistance Management Software
SC -	Service Coordinator
SCE -	Service Coordinator Entity
SNHTF -	Special Nursing Home Transition Funds
TBRA -	Tenant-Based Rental Assistance

Background and Overview of the Nursing Home Transition Program

The NHT program was developed to assist and empower individuals who want to move from a nursing facility back to a home of their choice in the community. The NHT program provides the opportunity for individuals and their families or caregivers to be fully informed of all long-term living options, including the full range of home and community-based services, and ensures they receive the guidance and support needed to make an informed choice about their long term living services. The program assists individuals in moving out of institutions and eliminates barriers in service systems so that individuals receive services and supports in settings of their choice.

NHT-related services as well as other home and community-based supports are provided in alignment with the individual's unique strengths, needs, choices and goals. The individual is the primary decision-maker and works in partnership with providers to develop an individual service plan. This process leads to personal empowerment, increased independence, greater community inclusion, self-reliance and meaningful, productive activities.

Goals and Objectives of the NHT Program:

- Empower individuals so they are involved to the extent possible in planning and directing their own transition from a nursing facility (NF) back into the community
- Develop the necessary infrastructure and supports in the community by removing barriers in the community so that individuals receive services and supports necessary to transition
- Expand and strengthen collaborations between aging and disability organizations to provide support and expertise to the NHT Program
- Help Pennsylvania rebalance its long-term living systems so that people have a *choice* of where they live and receive services.

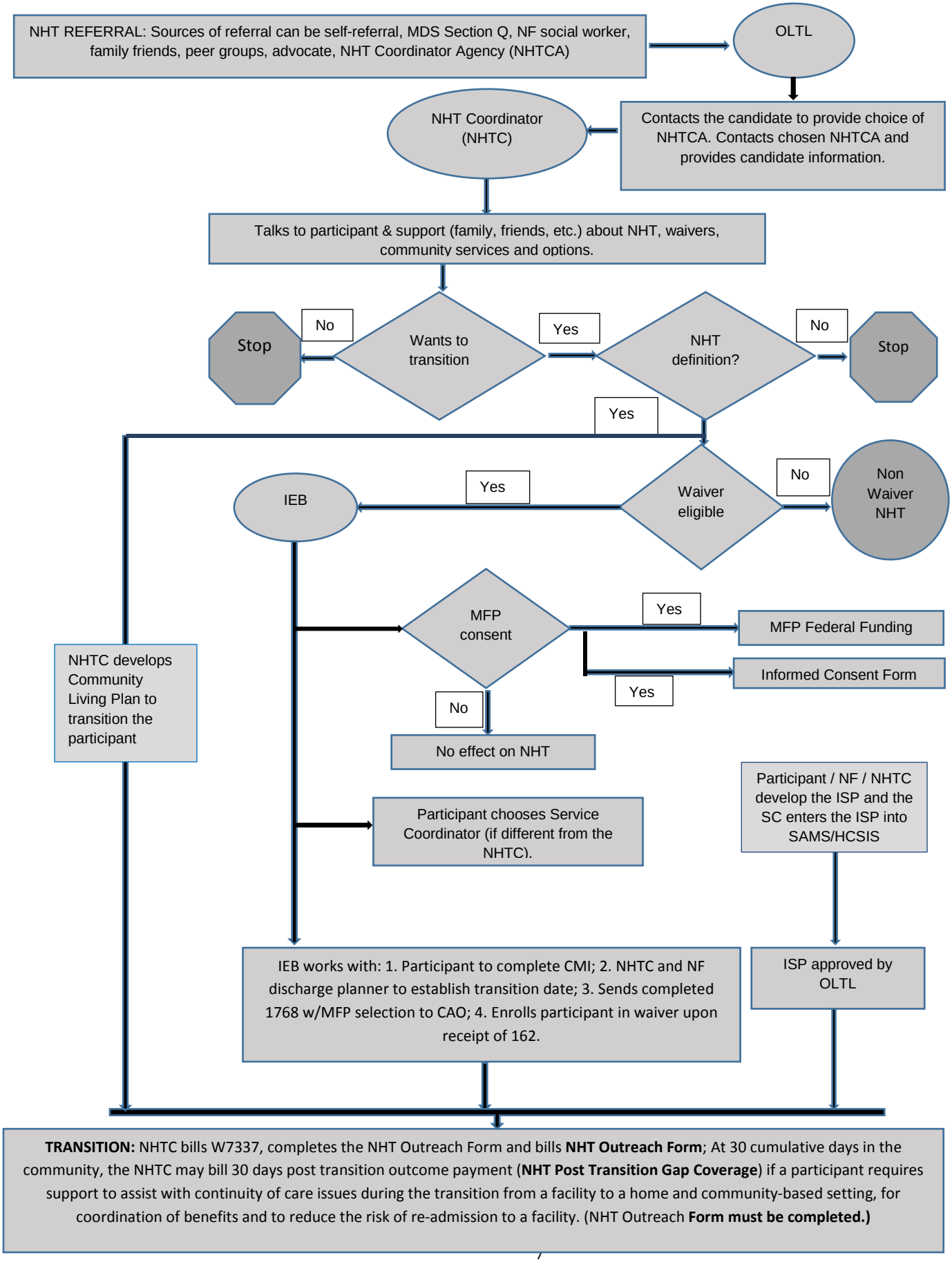
Benefits of NHT Participation

Some of the benefits available to NHT participants include:

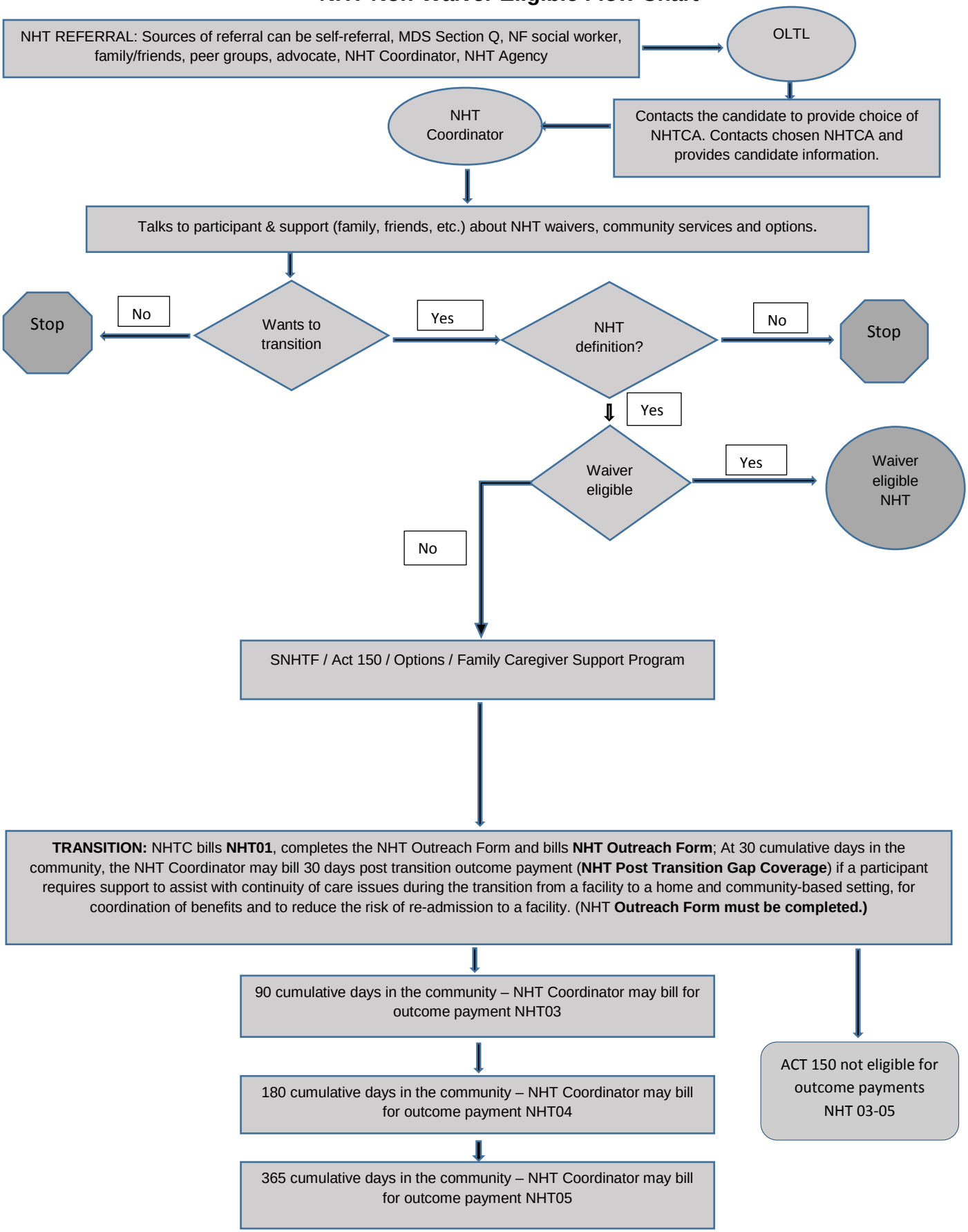
- Early education on long-term living services and guidance to individuals soon after admission into nursing facilities
- Full explanation of all options concerning long-term living choices
- Empowerment in making an informed choice about where and how they receive long-term living services and who provides the services
- Supports and guidance in transitioning to the community from the NHT coordinator
- Assistance in finding and obtaining housing and setting up a household, if needed
- Information and assistance for home and community-based services (HCBS) and other community programs
- Resources to assist with items such as security deposits, household items, adaptive equipment, utility deposits, and some other necessary expenses for an individual to establish his or her basic living arrangement and to move into their new living arrangement, if needed
- Assistance in identifying and eliminating barriers, enabling the individual to be better served in the community.

NHTCs work with individuals regardless of Medicaid waiver eligibility, income, assets, Level of Care Determination (LCD), or disability. The NHT Program works across populations, age groups, and program offices.

NHT Transition Services Coordination (W7337) Eligible Flow Chart



NHT Non-Waiver Eligible Flow Chart



Examples of transition coordination activities include, but are not limited to:

- Acting as a liaison between the facility where the participant will be transitioning from and the Independent Enrollment Broker (IEB) for waiver services
- Assessing for the appropriateness of a transition from an institution to the community, this includes gathering information about the need for health services, social supports, housing, transportation, financial resources and other needs
- Assisting the individual, family, nursing facility staff and others in the development of an integrated, coordinated Transition Support and HCBS Waiver Plan, including services provided through the nursing facility, add-on services, medical services (including Medicaid), behavioral health services, primary care, and other services to meet needs, ensure a safe discharge, and avoid hospital admissions or re-institutionalization
- Providing information to the individual about community resources and assisting the individual, family, nursing facility staff and others to ensure timely and coordinated access to Medicaid services, behavioral health services, financial counseling and other services to meet the needs of the individual.
- Assisting in finding and securing housing, including the completion of housing applications and securing required documentation (e.g., social security card, birth certificate, and prior rental history), working with private landlords, housing authorities, Regional Housing Coordinators (RHCs) or other housing entities
- Assessing the need for any home modifications that may need to be completed prior to the individual transitioning to the community; this includes acting as a liaison between the contractor, and physical and occupational therapists
- Assisting or coordinating training on budget management and educating the individual on available employment programs
- Coordinating the individual's move to the community and educating the individual on how to retain housing and on tenant rights and responsibilities
- Coordinating with Community Transition Services (CTS) available in the waiver by assisting in obtaining household supplies (including furniture) moving expenses, security deposits rental fee/deposits and health as safety costs
- Developing and recording the activities for transition and the coordination of services to allow the participant to live independently in the community
- Monitoring transition activities
- Coordinating the date of discharge. This includes notifying the IEB of the date of discharge

Participant

An individual is considered an NHT participant if they are not scheduled to leave the facility via the normal discharge process (including short term rehabilitative services), have expressed a desire to relocate from the facility **and** meet one of the following criteria:

- Participant has resided in an inpatient facility for a period of 90 consecutive days and is receiving MA services for one day and transition is completed through Transition Coordination activities.

  OR

- Participant has a documented barrier that was overcome through Transition Coordination activities regardless of nursing facility payer source or length of nursing home stay (except those indicated as being short term rehab who will transition via the normal discharge process).

Role of the Participant and Self-Determination
Self-determination is a key principle in nursing home transition. The principle emphasizes the importance of autonomy and the ability for individuals to take charge of all aspects of their lives. The goal is for persons moving from a nursing facility or other institutional setting to the community to regain control and be in charge of their lives.

Self-determination may include participants making decisions about:

- Their future
- The supports and services they want to receive
- Where they want to live
- How to spend their money
- The daily activities they want to engage in
- Employment/entering the work force

Participant Direction in NHT
Participant direction places an emphasis on what the participant wants and enables them to control their transition. To ensure the NHT process is guided by participant self-determination, the NHT Coordinator (NHTC) should not automatically take charge but should:

- Make sure participants lead the process to the fullest extent possible.
- Explain each step of the process to participants.
- Direct questions and decision-making back to the participants.
- Assist to clarify the participant's goals and personal choices.
- Encourage/expect participants to do as much of the planning as possible.
- Support participants and their support systems.

As the NHTC works with the participant, it may become necessary to schedule a meeting with other parties to discuss and begin to make progress towards transition. The meeting may include family or friends, nursing facility staff, community provider or other nursing home providers, etc.

Meetings should be directed by the participant to the greatest extent possible. Questions should be directed to the participant, and staff should avoid "talking over" the individual. Meetings give the participant the opportunity to express goals and possible fears about transitioning to the community. The NHTC can suggest inclusion of nursing facility staff, and others with skills that will insure a smooth transition process. It is important to remember to ask the participant if there are any family members and/or friends to invite.

Be aware that the dynamics within the group will change. Individuals who were passive can become more assertive; the participant may be interested and then lose interest; roadblocks can and will be raised by persons in the group. The NHTC needs to be prepared to handle whatever various situations the group dynamics may present.

A list of tasks should be developed based on the participant's goals and needs. They should be assigned and kept track of by the transition coordinator and the participant. The participant should be given copies of everything and made aware of what others are working on and receive regular updates.

The individual agrees to participate in the process by making appropriate efforts to complete the transition. He/she should be encouraged to take responsibility for as many tasks as they are capable (for example: telephone calls for housing applications, appointments to look at apartments, etc.). The tasks will vary from transition to transition depending on the participant's needs and preferences. Family members and friends should also be encouraged to take responsibility for tasks.

The NHTC should act as a facilitator in the transition process and not do all of the work for the participant. The process provides a good opportunity to experience what the participant is capable of and if his/her informal supports can be relied upon once the participant has transitioned to the community. The process also helps the participant build confidence and decrease their dependence. A participant directed transition will go a long way in supporting and empowering the individual to live in the community successfully.

NHT Coordinator (NHTC) and NHT Coordination Agency (NHTCA)

Guidelines for Working with Nursing Facility Staff

It is important for the NHTCA/NHTC to develop solid working relationships with nursing facility staff. The nursing facility staff can provide critical information and become an ally in the NHT transition process. To build the relationship with nursing facility staff:

- Be aware that there are a number of state agencies involved in nursing facilities. Familiarize yourself with their role and if possible get to know them. They include the Departments of Health (DOH), Human Services (DHS), and Aging (PDA), the Ombudsman, Adult Protective Services (APS), and the Auditor General (AG).
- Understand the effect of outside entities on nursing facilities because some visits are adversarial by nature. A positive relationship should be emphasized.

- Work to develop a positive working relationship with the administrator, social services, discharge planners, business office and other staff.
- You are a team member working with the individual to identify who should participate in supporting the transition, including nursing facility staff and/or therapy staff.
- Educate the staff about NHT, your role and their role in making it successful.
- Provide the nursing facility staff with written information about the NHT Program that they can give to the participant upon admission.
- Work together with nursing facility staff (admission, social services and nursing) to achieve goals. Get to know their roles, what each staff member does, and spend time informing them of your role.
- It is the responsibility of the nursing facility social worker to plan discharge from the nursing facility. NHTC is assisting with complex situations or needs.
- Utilize outside resources such as the Department of Human Services Field Operations Program staff when you experience issues with the nursing facility that you cannot resolve. Division Nursing Facility Field Operations Headquarters can be reached at 1-717-772-2570.
- Use this as an opportunity to educate staff about community services that they otherwise may not be familiar with.

NHTC

- Inform discharge planners and nursing facility staff about the NHT effort to secure their cooperation.
- Help individuals and their families see the full array of services and supports available to them.
- Provide individuals and their families with information about HCBS.
- Empower individuals to identify their own goals and desired outcomes.
- Develop personal/family directed transition plans, uniquely tailored to each individual.
- Identify risk factors that the individual's choices present and help them develop strategies to mitigate those risks.
- Help individuals to address methods to manage any factors related to:
  - Significant health care issues including behavioral health care needs
  - Safety issues
  - Financial concerns
  - Other relevant ongoing medical and community support needs
- Coordinate NHT-related services and supports to transition individuals into the community in collaboration with local housing authorities, Regional Housing Coordinators (RHC), the county mental health/mental retardation and other allied community agencies.
- Provide transition services including, but not limited to:
  - Assistance with securing housing
  - Home modifications
  - Home and community-based support
  - NF collaboration
  - Skills training and support
  - Formal and informal personal support
  - Caregiver support, ensuring that family members or friends have adequate support such as:
    - Training
    - Supplies
    - Assistance with forms and procedures
    - Advice and information
    - Encouragement
- Attempting to secure funds to establish the individual's basic living arrangement to be used for:

- Security deposits to obtain a lease on a living unit
- Specific set-up fees or deposits pertaining to:
  - Utilities
  - Telephone service
  - Electric and/or gas heating
- Essential household furnishings (bed, bedding, dining table and chairs, eating utensils and food preparation items, etc.).

Independent Enrollment Broker (IEB)

- Receive NHT participant data from the NHTC.
- Coordinate with the County Assistance Office (CAO) to ensure timely completion of the PA 600L or online COMPASS MA Application, if the candidate does not have an active MA record.
- Coordinate with the Area Agency on Aging (AAA) to ensure timely completion of the LCD.
- Complete in-home or in-facility visit with applicant to gather information for enrollment.
- Complete the Program Eligibility Determination.
- Identify, educate, and assist individuals to enroll in the Money Follows the Person (MFP) Rebalancing Demonstration.
- Share with the individual, who is qualified for both HCBS and MFP, the benefits of participating in MFP.
- Explain to the individual the process of completing and signing the Informed Consent Form.
- Provide participant with choice of NHTCs.
- Contact the chosen NHTC to:
  - Initiate and confirm NHT involvement for all MFP eligible participants.
    - NHTC will complete the NHT Outreach Form upon notification from the IEB.
  - Obtain the targeted transition date.
- Provide applicant with choice of Service Coordination provider if a separate organization from the NHTCA.
- Complete the required sections of the Care Management Instrument (CMI).
- Send a PA 1768 with the MFP Section completed to the local CAO for processing.
- Enroll applicant in waiver upon financial eligibility determination and receipt of PA 162.
- Send the completed Informed Consent Form to Temple University's Institute on Disabilities approximately **TWO WEEKS** prior to the targeted transition date.
- Transfer record and enrollment documentation to the selected Service Coordination Entity.

Service Coordinator / Service Coordination Entity (SC/SCE)

The Service Coordinator (SC/SCE) and NHTC may be one and the same. If not, the SC/SCE is responsible for the following activities:

- Submit the ISP developed by the NHTC, participant and nursing facility staff, to OLTL.
- Coordinate services and supports with all third-party payers, formal and informal supports, and other community resources to assure that funding sources through the HCBS waiver are the payer of last resort and there is no duplication of services.
- Document and justify the purchase of services or product and attempts to obtain or purchase through other resources (private insurance, Medicare, State Plan and any other local resources available).

- Authorize services or a combination of services selected or desired by the participant or the representative only when the participant's physical, cognitive, or emotional condition and overall activities of daily living (ADL) and instrumental activities of daily living (IADL) functioning require the service(s) to improve or maintain his or her functioning and/or condition.
- Implement and monitor the HCBS ISP consistent with timeframes and requirements of the waiver.
- Review and update the HCBS ISP at least annually within the re-evaluation due date and whenever the participant's needs change significantly.

DHS, Office of Long-Term Living (OLTL)

- The Department of Human Services, Office of Long-Term Living administers and oversees the NHT Program.
- Receive referrals for NHT candidates from a wide array of sources.
- Provides the NHT candidate a listing of qualified NHTCAs to choose from to provide NHT services.
- Provides the chosen NHTCA with the NHT candidate referral contact information.

DHS, Office of Income Maintenance, County Assistance Office (CAO)

- Reviews PA 600L for participant income eligibility for MA.
- Reviews the PA 1768 for participant eligibility for waiver.
- Sends the PA 162 eligibility determination for waiver notice to the participant and to the IEB.

Ombudsman

Role of the Ombudsman in Nursing Home Transition

Mandated by the Federal Older Americans Act, the Long-Term Care Ombudsman Program protects and promotes the rights and quality of life for individuals who reside in nursing homes. Ombudsmen have a hands-on working relationship with the residents and staff of the facilities in their areas and inform nursing home residents and their families of their rights. The nursing home ombudsmen program is available to all current residents and prospective residents.

Pennsylvania's Ombudsman office states: "The Ombudsman should not be appointed as the Long Term Living (LTL) Counselor for Nursing Home Transition (NHT) because it would prevent the Ombudsman from advocating on behalf of the participant if the individual does not want to transition to the community or problems arise with the transition process."

The Ombudsman may distribute pamphlets or other NHT material to make participants aware of the program. Additionally, the Ombudsman can refer individuals to NHT for services and/or referrals. Ultimately, the Ombudsman must ensure that individuals' rights are prominently identified and upheld throughout the entire NHT process.

A nursing home ombudsman should be contacted to resolve complaints from the consumer, request better individualized care and confidentially communicate problems and concerns about care and services at the nursing facility.

Chapter 3: Nursing Home Transition Coordination Agency / Coordinator Qualifications

NHT services require expertise to ensure the transition is successful. As such the NHTC must meet the following qualifications:

- All NHTCs, if also an SC, must sign the OLTL-HCBS Waiver Provider Enrollment Information Form specifying the waiver(s) you agree to service.
- NHTCAs must be located in and able to provide services in the Commonwealth of Pennsylvania.
- NHTCs are responsible to know, understand, and implement the NHT program activities in accordance with the policies and procedures established in this NHT Program Guidebook including any updates or changes to it.

Nursing Home Transition Coordination Agency Responsibilities

- Adhere to all responsibilities and conditions delineated in 55 PA Code Chapter 1101 and sign and adhere to the Medicaid Waiver Provider Agreement.
- Comply with Department of Human Services (DHS) standards, regulations, policies, and procedures relating to provider qualifications, including 55 PA Code Chapter 52.
- Be conflict free.
- Have IT systems compatible to DHS systems and to be able to communicate/function with state reporting systems.
- Pay for and obtain all licenses and certifications required for all staff who must access and use required systems, e.g. SAMS.
- Use and complete the NHT Outreach Form/SAMS database for each NHT participant and each participant enrolling in Medicaid-funded programs, state-funded programs, the Living Independence for the Elderly (LIFE) program, or Community HealthChoices (CHC).
- Provide NHT services to the over 60 and/or under 60 population.
- Establish collaborative housing relationships in the region they serve for NHT with entities such as Regional Housing Coordinators (RHCs), Housing Local Lead Agencies (LLAs), housing authorities, etc.
- Work effectively and cooperatively with Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), other Service Coordination Entities (SCEs), Housing LLAs, LIFE providers, and HCBS providers to assist participants in enrolling in Medicaid-funded programs, state-funded programs, the LIFE program, or CHC.
- Work effectively and cooperatively with the selected SCE to develop the Individual Service Plan (ISP) for HCBS.

- Possess extensive knowledge of HCBS providers and DHS programs within the geographic area they serve.
- Possess knowledge and experience with populations served in the OLTL and PA Department of Aging (PDA) HCBS programs.
- Document NHT services provided and actions taken.
- Assist nursing facility ineligible (NFI) and non-Medicaid eligible individuals in transitioning from nursing facilities to the community.
- Be able and willing to identify critical incidents and report and document them according to the processes and procedures outlined in OLTL Bulletin number 05-15-02, 51-15-02, 54-15-02, 55-15-02, 59-15-02 effective April 16, 2015, on Critical Incident Management.

NHTCA staff responsible for transition coordination activities must possess interviewing and assessment skills and must meet the same qualifications as Service Coordinators (SCs) as stated in 55 PA Code § 52.27.

Training

NHTCA staff must complete the following trainings:

- Use of SAMS, HCSIS, PROMISe, EVS, Social Serve, and any other state-required data systems.
- NHT 101 online training modules.
- Ongoing Health Insurance Portability and Accountability Act (HIPAA) training.
- Annual Adult Protective Services training for SCs addressing how to identify signs of abuse and neglect.
- Training in Enterprise Incident Management (EIM).
- Any other training deemed necessary by DHS.

NHTCA Agreement

The NHTCA agrees to the NHTC responsibilities with regard to the NHT Program, including:

- Accept referrals from OLTL.
- Contacting OLTL within seven calendar days in the event that the NHT referral cannot be accepted, so that another provider can be selected.
- Follow up with discharge planners on participants with scheduled discharge dates.
- Assist transitioning participants and their families, nursing facility staff, and others in the development of the Community Living Plan, including services provided through the nursing facility, add-on services, medical services, behavioral health services, and primary care.
- Coordinate Community Transition Services (CTS) and/or any available state funding or community resources necessary to obtain household supplies (including furniture), moving expenses, security deposits, rental fee/deposits, and health and safety assurances (one-time cleaning, pest eradication, etc.).
- Act as a liaison between the home modification broker, contractor, and physical/occupational therapists.
- Ensure that transitioning participants have Community Living Plans which are integrated and coordinated to avoid hospital admissions or other re-institutionalizations.
- Build local capacity to serve NHT participants by fostering relationships with social services,

nursing facilities, local charitable organizations, and other community-based outreach programs, e.g. housing authorities, United Way, County Assistance Office (CAO), etc.

- Coordinate with other NHTCs within the same service area to plan ongoing outreach and education about the NHT program to community agencies/organizations such as nursing facilities, hospitals, housing providers, etc.
- Coordinate with medical providers to ensure a safe and healthy discharge.
- Meet with new provider agencies and community supports (local housing authority, United Way, CAO, etc.) to plan and prepare for NHT activities.
- Retrieve, sort, and enter NHT data in systems and complete required forms on participants
- Perform a comprehensive assessment for the appropriateness of transition from an institution to the community. The assessment gathers information about need for health services, social supports, housing, transportation, financial resources, and other needs as well as financial and employment status.
- Assist individuals in understanding the range of community-based options, including HCBS and community resources.
- Assist participants, family, nursing facility staff, and others in applying for qualified services to ensure timely and coordinated access to Medicaid services, behavioral health services, state-funded services, financial counseling, Supplemental Nutrition Assistance Program (SNAP) benefits, and other services to meet identified needs.
- Assist participants in locating and securing housing, including the completion of housing applications, and working with private landlords, housing authorities, RHCs, or other housing entities.
- Provide or coordinate training for participants in budget management, tenant rights and responsibilities, and other topics as necessary.
- Assist participants in obtaining any needed documentation or resources required for Social Security, social services, community agencies, or housing, including coordinating with medical providers to obtain needed medical documents.
- Educate and counsel participants regarding employment programs and opportunities and make referrals to programs such as supportive employment, Office of Vocational Rehabilitation (OVR) programs, and Medical Assistance for Workers with Disabilities (MAWD).
- Other activities to support the NHT initiative.

HCBS Waivers

NHTCs will have an understanding of the process by which participants are enrolled into HCBS waivers. This includes:

- Working collaboratively with the Independent Enrollment Broker (IEB).
- Acting as a liaison between the IEB and the discharging nursing facility.

Quality Measures and Standards for Monitoring and Auditing Purposes

Monitoring and auditing NHTCAs ensures the NHT participants will receive the highest quality of service and have the education, opportunity and tools to successfully transition into, and reasonably expect to sustain their independence in, the community of their choice.

General provider monitoring includes at a minimum, evidence that:

- The service provider is licensed/credentialed.

- Employees/supervisors/ directors qualified/trained (request certifications) (following our service provider programmatic/procedures qualifications).
- Self-monitoring system in place.
- Training program in place.
- Reports OLTL may ask them to keep on hand – such as a record of how many referrals they receive, etc.
- Financial records/ data/reports- receipts for CTS/SNHTF, utilization, Funding Request, etc.
- Review several case files— MA number/payer source, POA, contact lists, LOC, evaluations, ISP, Participation Satisfaction Survey's Participants rights form, Signatures of participant/POA on all forms (they will need these for Community HealthChoices (CHC)), Protective abuse oversight (plan), Goals, Release of Information forms, case notes by NCQA/HEDIS standards (this includes who, what, when, how and time frame), coordination activities with other agencies, Incident reports.
- Records for complaints/ grievances.
- Incident Reporting Policy.
- Technical Assistance information for SCs/Participants/family members.
- Reports/data/information regarding any subcontractor's they use to work with participants.

Chapter 4: Nursing Home Transition Process

The normal discharge process occurs when the discharge is done by nursing facility staff, without involving transition coordination assistance from the NHTC. The normal discharge process from a nursing facility which does not involve information or transition coordination assistance from an NHTC is **not** considered a transition.

This description is supported by state and federal regulations.[1]

NHTCs work with individuals regardless of Medicaid waiver eligibility, income, assets, LCD, or disability. The NHT Program works across populations, age groups, and program offices.

It is important to note that the following steps outlined below may occur simultaneously and in any order depending on the identified transitioning needs of the individual.

1. OLTL will receive referrals for the program from many different sources:

    a) Nursing facility social worker
    b) Nursing facility staff based on MDS Section Q responses
    c) NHT coordinator

---

[1] **Commonwealth of Pennsylvania Regulations:**
§ 201.25. Discharge Policy: There shall be a centralized coordinated discharge plan for each resident to ensure that the resident has a program of continuing care after discharge from the nursing facility. The discharge plan shall be in accordance with each resident's needs.

Authority: The provisions of this § 201.25 amended under section 803 of the Health Care Facilities Act (35 P. S. § 448.803); and section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)).

Source: The provisions of this § 201.25 adopted August 29, 1975, effective September 1, 1975, 5 Pa.B. 2233; amended January 31, 1987, effective July 1, 1987, 17 Pa.B. 514; amended July 23, 1999, effective July 24, 1999, 29 Pa.B. 3999. Immediately preceding text appears at serial pages (202330) to (202331).

Federal Regulations:
Guidelines § 483.12: This requirement applies to transfers or discharges that are initiated by the facility, not by the resident. Whether or not a resident agrees to the facility's decision, these requirements apply whenever a facility initiates the transfer or discharge.

The facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility, if the facility ceases to operate (§ 483.12(a) (6).)

Interpretive Guidelines § 483.12(a)(7) - Orientation for Transfer or Discharge

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Sufficient preparation" means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence. Some examples of orientation may include trial visits, if possible, by the resident to a new location; working with family to ask their assistance in assuring the resident that valued possessions are not left behind or lost; orienting staff in the receiving facility to resident's daily patterns; and reviewing with staff routine for handling transfers and discharges in a manner that minimizes unnecessary and avoidable anxiety or depression and recognizes characteristic resident reactions identified by the resident assessment and care plan.

Interpretive Guidelines § 483.20(1)(3)

A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

A post-discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another nursing facility or Skilled Nursing Facility, or to another type of residential facility such as a board and care home or an intermediate care facility for individuals with mental retardation. Resident protection concerning transfer and discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's need will be met after discharge from the facility into the community.

Excerpts from the federal regulations **§ 483.12** can be found on pages 42-55 of the State Operations Manual Appendix PP. Excerpts from **§ 483.20** be found on pages 119-183.

d) Family/friends
e) Peer support groups
f) Individual / self-referral
g) Peer specialist
h) Advocate
i) Other

Note: All referrals should be made to OLTL. (Referral content, form and contact information is being developed and will updated with the final publication)

2. OLTL will contact the candidate, family/friends, designated representative or any other party so designated by the candidate and provides them with a listing of all eligible, enrolled, and qualified NHTCAs servicing the area of the candidate's target residence. OLTL will ask the candidate to choose 3 NHTCAs in order of preference.

3. OLTL will contact the chosen NHTCA and provided the NHT candidate information.

4. The NHTC will meet with the candidate to determine if he/she meets the NHT participant definitions. The NHTC will provide information, guidance and education regarding available HCBS programs. Help identify any barriers to transitioning, including waiver services and employment, and explore resources available to overcome those barriers. The NHTC will provide a full explanation of all Long-Term Services and Supports (LTSS) options and provides an opportunity for the individual to make an informed choice about where and how they will receive their LTSS services.
    a. If the individual is no longer interested in transitioning to the community the transition process ends.
    b. If the individual is undecided about transitioning to the community the NHTC will follow up with the resident and continue to educate the individual about transitioning to the community.
    c. If the individual is interested in transitioning to the community the NHTC will continue with the following steps.

5. When the individual makes an informed decision to transition to the community the transition coordination process begins. NHTC will begin coordinating and identifying the necessary services and supports to live successfully in the community.

Note: At this point, billable activities for NHT begin.

6. The NHTC will provide the participant's information to the IEB who will review the participant's information. If necessary the IEB will request a PA 600L to be completed. (Note: PA 600L's are only good for 60 days) The PA 600 will be accompanied with a PA 1768 Pending (a completed PA 1768 will be sent to the CAO upon completion of the form).

7. The IEB sends a Physician's Certification (PC) to the applicant's physician and requests an LCD be completed by the AAA in the county the applicant is currently residing.

8. The IEB completes the following forms:
    a) CMI (specific sections only)
    b) Service Provider Choice
    c) Freedom of Choice

d) HIPAA.

9. The IEB enters and submits the initial enrollment and plan into HCSIS / SAMS.

Note: If the NHT candidate does not meet clinical eligibility for waiver, the IEB's involvement in the NHT case ends.

10. The IEB will review the PC and LCD to determine clinical eligibility for HCBS programs. If the individual does not meet the eligibility requirements for HCBS, the NHTC continues with the customary transition process.

11. NHTC / staff complete section 1 and 2 of the NHT Outreach Form. These sections are used to collect initial individual and nursing facility data.

12. If an individual meets the eligibility criteria for MFP, IEB explains the initiative. If the individual agrees to participate the IEB completes Steps 13 and 18 below. <u>If the individual does not meet the eligibility criteria or does not want to participate in MFP, NHTC continues usual transition activities.</u>

13. For MFP participants only**,** IEB obtains appropriate signatures on the MFP Informed Consent form. This form provides a summary of the program along with the individual's Rights & Responsibilities.

14. For NHTCA who are not dual role as an SCE, the IEB will provide a list of SC/SCE's to choose from. Once selected, the participant, NHTC, SCE and nursing facility staff will develop the participant's ISP. SCE will submit the ISP to OLTL for approval.

15. The IEB works with the NHTC and nursing facility discharge planner to establish a transition date. The IEB will send the HCSIS / SAMS file and copies of the CMI and LCD to the SCE.

16. If the participant has an active MA record, the nursing facility sends the MA 103 discharge transmittal form to the CAO.

17. The NHTC should process and submit the Funding Request Form a minimum of ten (10) business days prior to the individual leaving the facility. Exceptions for expedited requests will be considered on a case-by-case basis. Additional instructions can be found on the form. Funding Request Forms should be submitted to: ra-transitionfunding@pa.gov.

18. The IEB also works with the participant and the CAO for timely completion of PA 600L, if needed, and sends the completed PA 1768 with MFP selection to the CAO. The IEB enrolls the participant in the authorized waiver upon receipt of the PA 162 from the CAO.

Note: *To meet the eligibility criteria for the MFP Program, individuals must enroll in one of the following Medicaid HCBS Programs:*

Aging Waiver	Attendant Care Waiver
COMMCARE Waiver	OBRA Waiver
Independence Waiver	LIFE

19. The NHTC / SCE receives the ISP authorization from OLTL and, together with the NHTC, implements a plan to successfully move the individual into the community. The NHTC completes the remaining sections of the NHT Outreach Form to document transition and post-transition data.

Chapter 5: Money Follows the Person (MFP)

The MFP Rebalancing Demonstration (hereafter referred to as MFP) is the largest single investment in home and community-based long-term living services ever offered by the federal Centers for Medicare and Medicaid Services. MFP is a federal initiative to assist certain individuals to move from institutions to home and community based services. These individuals include the elderly, individuals with physical disabilities, individuals with intellectual and/or developmental disabilities as well as individuals with mental illness.

MFP was enacted by the Deficit Reduction Act (DRA) of 2005, and is part of a strategy to assist the Commonwealth, in collaboration with stakeholders, to make widespread changes to the long-term service systems to help individuals living in nursing facilities, Intermediate Care Facilities/Intellectual Disabilities (ICF/ID) or state hospitals move back to their home or community.

Through successfully transitioning individuals from nursing facilities and enrolling individuals in the MFP, Pennsylvania receives enhanced federal funding on community services that will be used to create additional home and community based waiver opportunities for individuals in long-term care facilities.

Goals and Objectives of the MFP

- To help states like Pennsylvania rebalance its long-term living systems so that individuals have a choice of where they live and receive services. This will be done by shifting funding from institutions to HCBS.
- To assist individuals in moving out of institutions and providing an opportunity for them to live in the community, close to family and friends.
- To eliminate barriers in service systems, so that individuals receive services and supports in settings of their choice.

Eligibility

In order to qualify for MFP in Pennsylvania, individuals must:

- Have resided in a nursing facility, hospital, Intermediate Care Facility for Intellectual Disabilities (ICF/ID) or state hospital for at least 90 consecutive days.

Note: If an individual moves from one facility to another those days are counted toward the 90 consecutive days as long as there is not a move to the community in between nursing facility transfers.

- Be actively receiving Medical Assistance (MA) or Medicaid benefits for at least one (1) day prior to discharge/transition.
- Be transitioning to a Qualified Residence, defined by the federal government as:
    - A home owned or leased by the individual or the individual's family member.
    - An apartment with an individual lease that has lockable doors (inside and out), and which includes living, sleeping, bathing and cooking areas over which the individual or the individual's family has control.

    - A residence, in a community-based residential setting, in which no more than four unrelated individuals reside.
- Meet the eligibility criteria for one of the following state HCBS waiver programs:
    - Aging Waiver
    - COMMCARE Waiver
    - Attendant Care Waiver
    - OBRA Waiver
    - Independence Waiver
    - LIFE Program
- Consent to participate in MFP and sign the MFP Informed Consent Form.

Note: NHTC staff must continue with activities to transition the individual into the community if the individual does not meet the criteria for enrollment in MFP or a MFP qualifying Medicaid HCBS Waiver.

Establishing HCBS Waiver Eligibility (PA 1768 Form)

The Home and Community Based Eligibility Form (PA 1768) was developed to standardize the process of exchanging information between the agencies administering the various HCBS programs and the CAO.

To qualify for an HCBS program, an individual must first be evaluated to determine if the individual meets the program eligibility requirements and which HCBS program is appropriate to meet those needs. After the IEB completes this assessment and determination of program eligibility, the IEB then forwards the PA 1768 to the CAO.

Note: The NHTC must **not** forward the 1768 to the CAO, this is only to be done by the IEB.

The PA 1768 Form is the only form the CAOs will receive to document program eligibility for an HCBS program including MFP, and/or changes in the individual's status for an HCBS program or MFP. The PA 1768 received by the CAO must contain at a minimum the following information:

- Demographic applicant or recipient information
- Name of the Assessment Agency
- Assessor's Signature
- Assessor's Telephone Number
- Assessment Date
- Designated HCBS program

IMPORTANT: <u>An MFP code and the qualifying waiver must be marked on the PA 1768 if enrolling into MFP</u>.

Chapter 6: NHT Non-Waiver and Act 150 Eligible Individuals

Billing for NHT Services:
The individual is **NOT** eligible for service coordination in an OLTL waiver or program (Act 150, Options, FCSP, Nursing Facility Ineligible (NFI), Non-Care Managed).

Note: NHTCAs who are not dual role SCEs will bill for NHT activities using the procedures outlined in this chapter for transitioning waiver eligible, non-waiver eligible and Act 150 participants.

- All NHT 01 activities must be documented in the SAMS Service Deliveries using the Daily Unit Details calendar
  - NHT 01 activities are billed at the regional NHT 01 rate approved for your region.
  - No more than 32 units (8 hours) per day may be billed.
  - NHT 01 units are limited to 240 units per participant unless an exception has been pre-approved. An exception can be requested by emailing ra-nht@pa.gov and must be documented in the SAMS Journal Notes. Exceptions will be hard capped at 480 units. If a participant has complex needs necessitating additional units above the hard cap to successfully transition, justification must be provided and units pre-approved.
  - The reimbursement rate for transition coordination activities (NHT 01) is based on the current Service Coordination regional rate. This rate is broken down into four (4) regions across the state.
- The Service Delivery must contain a correct provider name.
- Must be documented in the daily unit details calendar in SAMS service delivery.
- The Service Delivery must contain units entered as whole numbers; partial units are not accepted. One unit equals 15 minutes.
- **NHT Outreach Form** - At the completion of the NHT Outreach Form, the NHT Outreach Form may be billed in SAMS Service Delivery for a payment of $250. This payment is only made once the NHT Outreach Form is completed in its entirety.
- **NHT Post Transition Gap Coverage** - The NHT Post Transition Gap Coverage may be billed in the SAMS Service Delivery for a payment of $250. NHT Post Transition Gap Coverage may be billed in specific instances during the first 30 days after transition when informal or formal services have not yet begun and specific risks must be addressed by the NHTC. These may include but are not limited to:
  - Arranging transportation to medical appointments.
  - Coordinating the delivery of Durable Medical Equipment (DME).
  - Continued assistance in the enrollment process for formal services.

Note: Billing NHT Post Transition Gap Coverage is contingent upon the completion of NHT Outreach Form. NHT Post Transition Gap Coverage was developed with the intent of providing support until informal or formal services are in place to prevent re-entry into the nursing facility.

Note: Outcome payments NHT03-05 are not billable for individuals accessing Act 150 services as these duplicate services that are within the Service Coordination definition.

- **NHT03** - At 90 cumulative days in the community, the NHTC may bill the NHT 03 outcome payment for $250 in the SAMS Service Deliveries. If the individual is receiving services through a care managed program such as Options or Family Caregiver Support Program (FCSP) the follow up may occur in the form of a telephone call. The follow up must occur in the form of a face to face visit.
    - You must document if the individual has resided in a nursing facility or hospital in the previous 90 days and, if so, for how many days.
    - Remember: Days in the hospital or nursing facility **do not** count toward the cumulative number of days. You may need to reschedule the follow up if you determine the individual has not met the 90 cumulative days in the community requirement.
- **NHT04** - At 180 cumulative days in the community the NHTC may bill the NHT 04 outcome payment for $500 in the SAMS Service Deliveries.
    - You must document if the individual has resided in a nursing facility or hospital in the previous 90 days and, if so, for how many days.
    - Remember: Days in the hospital or nursing facility **do not** count toward the cumulative number of days. You may need to reschedule the follow up if you determine the individual has not met the 180 cumulative days in the community requirement.
    - You must ask the individual if he/she would consider becoming a peer counselor or sharing their transition story. A peer counselor in this situation is an individual who would be willing to go back into the nursing facility and speak with other individuals about transitioning and living in the community.
- **NHT05** - At 365 cumulative days in the community, the NHTC may bill the NHT05 outcome payment for $750 in the SAMS Service Deliveries.
    - You must document if the individual has resided in a nursing facility or hospital in the previous 185 days and, if so, for how many days.
    - Remember: Days in the hospital or nursing facility **do not** count toward the cumulative number of days. You may need to reschedule the follow up if you determine the individual has not met the 365 cumulative days in the community requirement.
    - Document the individual's recommendation for improving the NHT Program.

Care Managed Instrument (CMI)

For non-waiver eligible individuals, the CMI will be completed by the NHTC. All sections of the CMI are required to be completed. Billable units allowable for this activity will be capped at 16 units (4 hours) and should be billed as NHT01.

DocuShare- Reimbursement/Billing

- NHT 01 activities should be captured in a SAMS service delivery. Ensure:
    - Within the service delivery the care enrollment should be "NHT Care Enrollment".
    - Provider name is correct.
    - Correct units and unit price is correct.
    - Daily unit details calendar is complete.
- Reports are run at the beginning of each month for:
    - NHT 01 activities.
    - NHT Outreach Form for waiver and non-waiver eligible.
    - NHT Post Transition Gap Coverage for waiver and non-waiver eligible.
    - NHT 03-05 activities for non-waiver eligible individuals (excluding Act 150 participants).
- DocuShare reports are posted monthly into each NHTCs folder.

Note. To establish a DocuShare folder please email RA-pwoltldocushare@pa.gov.

- On the date of Transition, the units captured within the SAMS Service Deliveries for up to 180 day preceding transition are billed as NHT 01 at the assigned regional rate. The service deliveries remain in SAMS, and serve as documentation of when the service was provided, number of units delivered, and duration.

    - **Transition Coordination units that are provided outside of the 180 days prior to the date of transition are to be billed in SAMS Service Delivery as NHT 01 at the assigned regional rate. The 180 day window follows the transition progression. Oldest activities greater than 180 days are paid at the end of each month on a rolling basis.**

    - **Transitions that fail (individual does not transition for any reason) are to be billed as NHT 01 activities in the SAMS Service Delivery at the assigned regional rate.**

It is the responsibility of each NHTC to track what is being billed and to reconcile their billing records with the reports provided in DocuShare.

Chapter 7: NHT Transition Service Coordination - W7337 - Waiver Eligible Individuals

In accordance with CMS guidance, participants being enrolled into a waiver may receive transition service coordination services while they are still institutionalized, for up to 180 consecutive days prior to discharge. However, payment may only occur on the date when the individual leaves the institution and is enrolled in the waiver. In such cases, the transition service coordination activities conducted while the person was institutionalized are not considered complete until the person leaves the institution and is enrolled in the waiver. Therefore, OLTL has included transition service coordination in the OLTL waivers as part of the Service Coordination service definition located in Appendix C: 2 of the waiver:

"Service Coordination includes functions necessary to facilitate community transition for participants who received Medicaid-funded institutional services (i.e. Nursing Facilities) and who lived in an institution for at least 90 consecutive days prior to their transition to the waiver. Service Coordination activities for participants leaving institutions must be coordinated with, and must not duplicate, institutional discharge planning. This service may be provided up to 180 days in advance of anticipated movement to the community"

Effective December 1, 2016, if an individual has resided in a nursing facility for at least 90 consecutive days, is transitioning from the nursing facility to a home and community-based waiver setting, is not scheduled to leave the facility via normal discharge procedures, and is approved for and enrolling into an OLTL waiver program, the transition coordinator must document all transition coordination activities on the participant's Individual Service Plan (ISP) and bill through the waiver using the W7337 procedure code for activities provided within the 180 days prior to the transition.

Note: The NHTCA must also be a qualified SCE in order to bill Transition Service Coordination (code W7337). If the NHTCA is not a qualified SCE, billing for transitioning a participant to waiver will be through NHT01.

Note: SCEs are strongly encouraged to enroll to provide services in all OLTL waivers. If an SCE does not enroll as a provider for all OLTL waivers, <u>they are assuming the risk of non-payment for Transition Coordination Services</u> provided to an individual who enrolls in a waiver for which the SCE is not enrolled as a provider. In this case neither W7337 nor NHT 01 may be billed.

MFP and the role of the IEB

When a potential MFP candidate is identified, the IEB is responsible for obtaining the participant's signature on the Informed Consent Form. The IEB must also send the PA 1768 to the CAO.

Note: The NHTC must **not** forward the 1768 to the CAO, this is only to be done by the IEB.

MFP and the role of the NHTC

- IEB will contact the NHTC assigned to a specific region or county for **<u>all</u>** eligible MFP participants. NHTC is tasked with the completion of the NHT Outreach Form and may bill NHT Outreach Form for the completion of the NHT Outreach Form when the individual meets the criteria for MFP.
- In many cases, the individual may not be currently enrolled in the NHT program or meet the criteria to be considered an NHT participant, however, in order to capture MFP data the completion of the NHT Outreach Form for these individuals is required regardless of whether

NHT participant criteria are met.

Note**:** In these cases NHT Outreach Form may be billed, however unless the individuals meets the NHT participant criteria, no further NHT follow-ups or outcomes may be billed.

- The NHT Outreach Form continues to be a requirement for all other participants who meet the NHT participant definition.

- An MFP participant is not necessarily an NHT participant unless the individual meets the NHT participant definition and requires transition coordination activities. For those who meet the NHT participant criteria, NHT Outreach Form completion and, if there is a documented need, the NHT Post Transition Gap Coverage may be billed for waiver eligible individuals. For non-waiver eligible individuals who meet the NHT participant definition NHT Outreach Form, NHT Post Transition Gap Coverage, and NHT 03 - 05 may be billed. Please refer to the NHT participant definition.

Billing for NHT Transition Services Coordination (Code W7337)

For those individuals waiver eligible, (Aging, Attendant Care, OBRA, COMMCare, Independence) transition services provided within 180 days prior to the date of a transition for individuals who meet the service coordination definition outlined in Appendix C: 2 of the waiver, and are transitioning from an institutional setting may be billed as a service using billing code W7337. In order for this code to be billed the NHTC must:

- Document all transition coordination activities in the SAMS Service Deliveries using the Daily Unit Details calendar
    - The service deliveries are entered in real time
        - Coordination activities are billed at the regional Service Coordination rate
        - No more than 32 units (8 hours) per day may be billed
        - NHT 01 units are limited to 240 units per participant unless an exception has been pre-approved. An exception can be requested by emailing ra-nht@pa.gov and documented in the SAMS journal notes. Exceptions are hard capped at 480 units. If a participant has complex needs necessitating additional units above the hard cap to successfully transition, justification must be provided and units pre-approved.
        - The Service Delivery must contain a correct provider name.
        - The Service Delivery must contain units entered as whole numbers, partial units are not accepted. 1 Unit equals 15 minutes.
        - Units must be documented in the daily unit details calendar.
- On the date of Transition, the units captured within the SAMS Service Deliveries for transition activities completed within 180 days prior to transition are billed as a lump sum to the Waiver ISP under W7337 either in the HCSIS ISP or the SAMS ISP. The NHT 01 service deliveries remain in SAMS, and serve as documentation of when the service was provided, number of units delivered, and duration.

    - **Transition Coordination units that are provided outside of the permitted 180 days prior to the date of transition are to be billed in SAMS Service Delivery as NHT 01 at the assigned regional rate. The 180 day window follows the transition progression. Oldest activities greater than 180 days are paid at the end of each month on a rolling basis, as NHT01 activities. These will appear on the monthly DocuShare reports.**

- **Transitions that fail (individual does not transition for any reason) are to be billed as NHT 01 activities in the SAMS Service Delivery at the assigned regional rate.**

- **NHT Outreach Form** is billed in the SAMS Service Delivery on the date of transition for individuals who meet the NHT participant definition and have a completed NHT Outreach Form. The NHT Outreach Form is a payment of $250.00. The NHT Outreach Form will not pay without a completed NHT Outreach Form.

.

- **NHT Post Transition Gap Coverage-**The NHT Post Transition Gap Coverage may be billed in the SAMS Service Delivery for a payment of $250.00. NHT Post Transition Gap Coverage may be billed in specific instances during the first 30 days after transition when formal services (service coordination, care managed programs (i.e. Act 150, Options, FCSP)) have not yet begun and specific risks must be addressed by the NHTC. Activities must be documented in SAMS journal notes. These may include but are not limited to:
  - Arranging transportation to medical appointments.
  - Coordinating the delivery of DME.
  - Continued assistance in the enrollment process for formal services.

    - **Billing NHT Post Transition Gap Coverage is contingent upon the completion of NHT Outreach Form. NHT Post Transition Gap Coverage was developed with the intent of providing support until formal services are in place.**

    - **Outcome payments NHT03-05 are not billable for individuals accessing waiver services as these duplicate services that are within the Service Coordination definition.**

Note: All NHT01 activities must be billed and dated prior to, or on the date of the NHT Outreach Form being billed which is the date of transition. NHT01 activities cannot be billed for transition coordination provided after the date of transition.

***Case Examples*:**
There may be instances in which the MFP status of an individual will change throughout the course of a transition. For example, an NHTC may receive a referral for an individual shortly after nursing facility admission. The individual may not meet the required 90 consecutive days with at least 1 day of MA services initially; however a barrier may be identified. As long as the individual meets the NHT participant definition outlined the NHTC may work with the individual. From the date of nursing facility admission (day 1) to day 89, the NHTC would bill NHT01 activities. From day 90 through day 270 (180 day span) W7337 would be billed upon the transition date from the nursing facility. Day 270 would be the transition date.

The 180 day window follows the transition progression. Oldest activities greater than 180 days are paid at the end of each month as NHT01 on a rolling basis.

Community Transition Services (CTS) for Medicaid Waiver Eligible Participants
CTS is an umbrella term used to describe supports and services designed to assist individuals to move out of institutional settings and back into the community. CTS funding can help pay for services and goods essential to establishing residency in the community.

CTS in Pennsylvania are supported by two different funding sources. For Medicaid eligible individuals who meet waiver qualifications, CTS may be available up to $4,000 per consumer, per lifetime. These services and supports would be needed in instances in which the individual has the desire to live in the community but does not have the support systems or financial means necessary to make the transition from an institutional setting to the community.

For Medicaid waiver eligible individuals who wish to transition from an institution to their own home, apartment, or family/friend/living arrangement may use CTS funding to pay the necessary expenses to move into the community living arrangement of their choice and establish their household.

Notes:

- Expenditures must be prior authorized.
- Expenditures may not include on-going payment for rent.

The following are categories of expenses that may be incurred:

- **W7332** - Equipment, essential furnishings and initial supplies (e.g. household products, dishes, chairs, tables).

- **W7333** - Moving Expenses

- **W7334** - Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement

- **W7335** - Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating).

- **W7336** - Personal and Environmental health and safety assurances (e.g. pest eradication, allergen control, one-time cleaning prior to occupancy).

Five of Pennsylvania's Home and Community Based Service (HCBS) waivers provide for funding to assist eligible individuals to transition from nursing facilities:

- Aging
- Independence
- OBRA
- Attendant Care
- COMMCare

Note: Service orders in SAMS are uploaded to HCSIS on a daily basis. When the provider bills through PROMISe, PROMISe checks the Service Order in HCSIS. If the Service Order in HCSIS and provider billing in PROMISe do not contradict each other, PROMISe will pay the provider.

Reimbursement Process Waiver CTS:

- Once the funding request is approved by the OLTL NHT Team, the NHTC notifies the selected Service Coordination Entity (SCE) who enters the following on the Waiver ISP:

    - The good or service that was approved.
    - The total unit price approved for each good or service.
- If the Waiver ISP is captured in HCSIS a request to the SCE for a screen shot ensuring services were entered correctly may be requested.
- If the waiver ISP is captured in SAMS all services must be ordered in SAMS under one of the CTS identifiers in SAMS on or after the approval date of the CTS request.
- The service delivery dollar amount must be equal to or less than the approved service order amount and may not exceed the approved amount.
- If an approved amount is not needed, the agency must send an e-mail to the ra-nht@pa.gov mailbox stating why the funds were not needed. If there is an increase in the cost of the items/services from the original Waiver CTS, it is necessary to submit a revision of the funding request. This request will require approval from OLTL NHT Team.
- Based on the approved ISP reimbursement occurs through Promise to the agency for the cost of services provided.
- Receipts – All Receipts must be kept on file for audit purposes and could be requested as proof of purchase.

Care Management Instrument
For waiver eligible individuals, the IEB will be completing required sections of this assessment form.

Non Billable Services or Time
NHT may not be billed during the time that a waiver ISP is on hold for up to 180 days while a participant is in a facility. (For example, if a participant is hospitalized, the SC is responsible to assist the participant in transitioning from the hospital setting back to his/her community setting where he/she was receiving waiver services.)

See billing bulletin at the web address below – page 5:
http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/p_033878.pdf

These tasks include:
- Housing
- Home modifications
- Increase in services through the ISP process
- Obtaining DME
- Addressing any other barrier that may arise that would prevent the individual from returning to the community and resuming waiver services

The NHTC may not bill for the completion of a CMI for waiver eligible participants.

NHT 03-05 may not be billed for waiver enrolled participants.

Chapter 8: Special Nursing Home Transition Funding

Special Nursing Home Transition Funds (SNHTF) were developed to provide a way for individuals in a nursing home or other institutional setting to access financial assistance and services when existing programs or community resources are unable to help them transition to the community. These funds are for those individuals who would not be able to successfully transition into the community without such assistance because of an identified barrier and should not be participants who would leave the nursing facility via the normal discharge process (i.e. short term rehabilitation). These funds enable an individual to return and remain in the community and may increase their quality of life.

This funding is provided through state-only dollars, is limited based on available funding, is reviewed on a case-by-case basis and mirrors the transition services available through Medicaid waivers.

Eligibility Requirements

Subject to the availability of funds, eligible individuals must meet **at least one** of the following requirements:

- CTS funding from HCBS Waivers has been exhausted
- Currently receiving MA services in the nursing facility, but ineligible for waiver services in the community
- Diverting individuals from nursing facilities who are MA eligible or would likely become MA eligible within six (6) months
- Nursing Facility Clinically Eligible (NFCE) and be enrolled in Act 150, Options or participating in the FCSP
- Nursing Facility Ineligible (NFI) with a barrier to returning to the community with planned safeguard to remain in their community
- NFCE, financially ineligible for waiver and has a barrier which prevents them from returning to the community

Note: Individuals who refuse MA services will not be considered for SNHTF. Individuals may be eligible for SNHTF if it is documented that they do not qualify for funding from a third party payer.

Goods and Services Provided:

SNHTF may be utilized to pay for the following:

- One-time transitioning expenditures that provide the necessary support for the individual to return and remain in the community as well as improve his/her quality of life as determined by the OLTL NHT staff. The expenditures could include items such as:
    - Equipment, furnishings and initial supplies such as household products, dishes, chairs, tables, etc. These items should only be items that enable an individual to return and remain in the community and increase his/her quality of life.
    - Moving expenses.
    - Security deposits or other such one-time payments required to obtain or retain a lease on an apartment, home or community living arrangement.
    - Set-up fees or deposits for utility or service access including telephone services, electricity, sewer, garbage, water and heating.

- Personal and environmental health and safety assurances (i.e. pest eradication, allergen control, one-time cleaning prior to occupancy, etc.).
- Stranded costs - Costs incurred when an individual does not transition after authorized service costs have occurred.
- Grocery items up to $200 when all other resources such as community aid, food banks, and stamps have been exhausted or are not available.

Note: SNHTF may **not** be used for rent, personal debt relief, televisions, and cable or internet services, (unless used for an adaptation device for the individual to help him/her remain in the community and increase his/her quality of life.

Request Procedures

SNHTF may be requested when the individual has a clearly identified barrier that prevents their transition to the community.

SNHTF requests shall be submitted prior to the individual being discharged. Untimely requests will be reviewed on a case-by-case basis when the NHTC submits a detailed explanation of the circumstances which prevented the request from being made in a timely manner.

Application Process and Required Documentation

Requests for SNHTF must clearly justify that the individual meets at least one of the eligibility requirements (i.e. individuals transitioning out of nursing facilities or those who are eminently at-risk of placement into a nursing facility, etc.).

Any NHTC requesting SNHTF must complete the Funding Request Form and complete the SNHTF process within SAMS for each individual that meets the criteria for SNHTF. Failure to complete the process in its entirety may result in a delay of a decision and payment of the request.

The completed Funding Request Form must be e-mailed to the following address: ra-nht@pa.gov.

Funding Request Form

A Funding Request Form must be submitted two weeks prior to the targeted transition date.

Form completion - NHTCs must submit ALL applicable requested information (rehabilitation services being received, income, resources, and identified barrier to transition, informal supports, and all other requested documentation). The form should include a clear description of services the individual is eligible or ineligible to receive, including why the individual was denied or has declined any services, including waiver services.

The OLTL NHT Team will respond to the funding request within seven (7) business days. The OLTL NHT Team will send correspondence to the requesting agency by completing activities and referrals in SAMS, adding a journal note in SAMS, and notify the agency via email of approval, denial or request additional information or clarification.

When additional information or clarification is requested, the agency requesting funding must provide that documentation to the OLTL NHT Team within seven (7) business days for final approval or denial.

Once the SNHTF or waiver CTS are approved, the form is returned to the agency noting the total amount of services and funding approved. The services are approved based on totals of each category (i.e. security deposits, household goods, etc.) on the submitted Funding Request Form. If there is an increase in the cost of the items/services from the original request, it will be necessary to submit a revision of the Funding Request Form. This revised request will require prior approval from the OLTL NHT Team.

Reimbursement Process for SNHTF

Reimbursement for SNHTF occurs on a quarterly basis. The process for reimbursement occurs as follows:

- Once the funding request is approved by the OLTL NHT Team, the NHTC authorizes one or more transition services and initiates a service order in the NHT Care Program in SAMS on or after the approval date of the request.
- A Service Order and Service Delivery are entered into SAMS with the correct dollar amount approved.
- All services must be ordered in SAMS under one of the NHT identifiers on or after the approval date of the SNHTF request.
- The service delivery dollar amount must be equal to or less than the approved service order amount and may not exceed the approved amount.
- Both the service order and the service delivery amount must be less than or equal to the service allocation amount indicated in the NHT care plan/service plan.
- If an approved amount is not needed, the agency must send an e-mail to the ra-nht@pa.gov mailbox stating why the funds were not needed. If there is an increase in the cost of the items/services from the original SNHTF request, it is necessary to submit a revision of the funding request form. This request will require approval from OLTL NHT Team.
- Based on SAMS service delivery information, OLTL/PDA reimburses the agency for the cost of services provided on a quarterly basis.
- All receipts must be kept on file for audit purposes and could be requested as proof of purchase.
- Each agency's quarterly report is posted to their DocuShare folder.To establish a DocuShare folder, please email RA-pwoltldocushare@pa.gov

Chapter 9: SAMS

SAMS/Omnia are the central repositories for assessments, demographics, service plans and costs for consumers receiving a wide variety of services within several different service programs, including nursing home transition.

Documentation

Documentation remains a critical part of the NHT Program. Clinical documentation and record keeping are often overlooked, but it is important to show a longitudinal record of the participant's transitional history. Basic standard practices should be followed. It is important to document in the Journal Note area of SAMS, the services you are providing and the decisions you are making regarding the participants you are working with. The documentation should include what was done, by whom, why and what the results are. When in doubt, it is always better to document.

Specifically, the following situations should be documented:

- Any and all transitions that are cancelled and the reasoning behind the cancellation.
- One participant having multiple transitions that fall within the same 365 day period.
- When declining to assist with a transition, please document why, (i.e. what risks are unable to be mitigated, and/or why the transition will not be safe, and/or what barriers cannot be safely/adequately overcome to ensure a safe discharge).
- ISP--Document Community Living Plan and the NHTC's role in developing the ISP. The Community Living Plan should include, but is not limited to, waiver services, mental health or substance abuse counseling and services, any other OLTL, Office of Developmental Programs, Office of Mental Health and Substance Abuse Services, or PDA programs, any services or programs provided by Office of Income Maintenance or charitable community organizations.
- Home modifications.
- State when W7337 or NHT01 units are exceeded or when more than 32 units per day are billed in the SAMS Service Delivery.
- Contact with the IEB and service coordination agency.
- Document the outcome visits of NHT 03-05 contacts with the participant.
- Document the reason(s) NHT Post Transition Gap Coverage was utilized and circumstances creating the necessity for coverage.

Proper documentation of standards and practices ensures the accuracy and legitimacy of services provided in accordance with the NHT Program requirements and procedures.

Documentation in SAMS

The NHTC's documentation demonstrates all NHT service coordination activities that are provided to each participant registered in the NHT Service Program in SAMS. To document NHT participant activities and spending:

- Open a record in SAMS for the participant if one is not already opened.

- Enter a non-care managed care Enrollment (if individual is over 60).
- Enter an OLTL Community Care Enrollment (if individual is under 60).
- Enter an NHT care enrollmen.t
- Enter the **Default Provider.** Default Provider should always be indicated as being the NHTC who is currently working with the individual toward transition.
- Enter the **Default Agency.** Regardless of programmatic eligibility or enrollment, in SAMS the "Default Agency" is always the Area Agency on Aging (AAA) in the county in which the individual is residing. This AAA will be completing the Level of Care Determination. When the individual moves to another county the "Default Agency" will change to the AAA in that receiving county. The only time the "Default Agency" is not the AAA are those few cases in which an individual will never require an assessment by the AAA office. In those few instances the "Default Agency" will be Office of Long Term Living (OLTL).
- Add an NHT Care Plan. Within the NHT Care Plan a Care Plan Worksheet for Non Waiver eligible and Waiver eligible individuals needs to be created and completed. This ensures that all identified risks are documented and addressed. The individual may opt to assume risks that cannot be mitigated or negated through state or federal programs, informal supports, or community resources.
- Enter Service Deliveries for billable NHT activities. Ensure:
    - Provider name is correct.
    - Correct units and unit price is correct.
    - Daily unit details calendar is complete.
    - Upon completion of a transition or once an NHT participant is closed to the program end date the NHT care enrollment.

Chapter 10: Training Information in LMS

Creating an LMS Account:

- From the LTLTI homepage, www.ltltrainingpa.org, select Register your training account (located on the right side of the page).
- Select 'I am the first member of my organization to use the LTLTI LMS'. This option will create an account immediately.
- Enter the Captcha words; select the green 'Next' button.
- Enter an email address, password, first name, last name and title.
- Within the Your Training Area on this page, check the 'Housing and Nursing Home Transitions' box (and any other training categories that you are interested in) and select the green 'Next' button.
- Follow the instructions in the email that will be sent to the address you provided.

Logging into the LMS:

- From the LTLTI homepage, www.ltltrainingpa.org, select Log into your training account (blue button on the right side of the page).
- Enter your email address and password.
- The page with the big, colorful icons is called the 'Dashboard'. This is the 'Home' page of the LMS.

Displaying NHT resources:

- From the Dashboard of the LMS, select 'Resource Archive' (3 green books).
- Click on the tan folder labeled 'Housing Resources and NHT'.

Note: The NHT 101 and Housing online training modules are easily accessible from this page under the "Group by Program" tab.

- Click on the 'Show All' tab.
- You will find a list of all of the NHT resources.
- Click on the small, green arrow to the left of the resource title to open the resource.

General LMS questions:

- From the Dashboard of the LMS, select 'Help' (blue question mark).
- You will find a list of 'Help' items to assist you.
- If you have any questions, please call Diana Linn at LTLTI at 717-541-4214.

Additional training information:
SAMS (NHT Modules) can be found at Long Term Living Training Institute website at:
http://www.ltltrainingpa.org/lms/index.php?option=auth&task=recovery&token=6fd9173eea74df19f2a5c11986361b32e5f638c6

Chapter 11: NHT Outreach Form

Completing the NHT Outreach Form is a critical process which helps provide the OLTL with required information needed for reporting to CMS. The information is used to evaluate the NHT Program, identify barriers, receive enhanced federal funding and allocate resources in an effective manner. Completing the necessary sections and entering them into the SAMS database in a timely manner is critical. It is also directly linked to payment for NHT Outreach Form.

The NHT Outreach Form is completed in SAMS for each participant who meet the following required criteria:

- The NHTC informs the participant (regardless of MA eligibility) about the transition process.
- The participant decides and consents to transition to the community from a nursing facility.
- The participant receives transition coordination activities and the individual meets the NHT participant definition.

  OR

- The individual is MFP eligible (regardless of whether or not they are enrolled in the NHT Program).

Completing the Form:

- **Sections 1 and 2** document *initial* participant and nursing facility data. The NHTC completes Sections 1 and 2 once the participant and/or family makes an informed decision to transition to the community and meets the other criteria identified in the O*verview* above.

- **Sections 3 and 4** document transition and post-transition data. The NHTC completes Sections 3, 4, and 5 during and after the participant's transition to the community.

- **Section 5** documents required additional post-transition data that is specific to participants in the MFP Rebalancing Demonstration.

When the NHT Outreach Form is complete, it is stored in an electronic form in the Commonwealth's Omnia repository and becomes part of the participant's record in Omnia and SAMS.

Note: It is important to record all transition candidates who receive NHT transition coordination, whether or not the individual completes transition, receives any services, or enters a waiver or other state funded program.

Note: DO NOT complete the NHT Outreach Form if the individual's transition was a normally scheduled nursing facility discharge and did not require NHT support intervention and was not a participant of MFP.

Chapter 12: Cross County Transitions

The necessity for Cross County Transitions arise when an individual is currently residing in a nursing facility or institutional setting in one county but desires to transition into another county for permanent residency.

Waiver Eligible

For individuals transitioning onto a Medicaid waiver program (Aging, OBRA, COMMCare, Attendant Care, and Independence) the selected NHTC will work directly with the selected SCE in the receiving county to ensure a safe and orderly transition across counties.

Upon discharge, the NHTC will bill W7337 to the waiver ISP for the transition coordination activities they completed.

Note: The NHTCA must also be a qualified SCE in order to bill Transition Service Coordination (code W7337). If the NHTCA is not a qualified SCE, billing for transitioning a participant to waiver will be through NHT01.

Non-Waiver Eligible

For individuals transitioning into a **CARE MANAGED** Program (Options, FCSP, ACT 150), the selected NHTC will work with the selected care manager or SC in the receiving county.

The NHTC will bill NHT 01 activities for transition coordination activities.

Non-Care Managed

For individuals transitioning that are considered to be Non-Care Managed, meaning they will not be followed by a service coordination entity or care manager for a state or federally funded HCBS program, the NHTC will work with the individual, family, or other informal supports in the cross county transition. Individuals who fall into this category may be considered to be NFI, receiving only a PERS unit, or HDM (Home Delivered Meals).

The NHTC will bill NHT 01 activities for transition coordination activities.

Chapter 13: LIFE Program

LIFE providers often receive direct referrals for individuals transitioning into the LIFE Program. If a referral is made directly to the LIFE provider, that LIFE provider may contact the NHTC in some instances due to the fact that the LIFE provider cannot access the NHT Outreach Form. If contacted, the NHTC will:

- Contact the individual
- Complete all sections of the NHT Outreach Form
- Complete the Daily Units Details Calendar
    - NHT Outreach Form may be billed for the completion of the NHT Outreach Form. This would include time spent communicating with the LIFE provider.
- Enter a journal note in SAMS indicating the completion of the NHT Outreach Form

Please note that NHTCs may bill NHT Outreach Form for the completion of the NHT Outreach Form; however, NHT Post Transition Gap Coverage and NHT-03 through NHT-05 activities may **not** be billed for these participants. In addition, NHTCs may **not** access Special Nursing Home Transition Funds (SNHTF) for individuals enrolling into the LIFE program. This is in accordance with Title 42 CFR §460.182 Medicaid Payment, subsection C**.**

Regional Housing Coordinators

DHS partners with Pennsylvania Housing Finance Agency (PHFA) and Self-Determination Housing Project (SDHP) to support Regional Housing Coordinators (RHC).

Pennsylvania Housing Finance Agency (PHFA): PHFA's mission is "In order to make the Commonwealth a better place to live while fostering community and economic development, the PHFA provides the capital for decent, safe, and affordable homes and apartments for older adults, persons of modest means, and those with special housing needs."

Self-Determination Housing Project (SDHP): SDHP is a non-profit organization who works to expand housing options for people with disabilities. They provide outreach, education, advocacy, policy development, technical assistance, programs and initiatives.

Regional Housing Coordinators (RHCs): The RHCs work with others to facilitate access to housing opportunities, suggest housing options for individuals with disabilities, educating service providers, providing outreach and developing collaborative relationships with other groups and agencies.

There are 10 RHCs and the State-wide Program Coordinator. For more information on RHC contact:

Mary Penny, Statewide Housing Coordinator

Voice: 610-873-9595

Toll-free: 877-550-7347

E-mail: mary@sdhp.org

Website: www.sdhp.org

NHT Tenant Based Rental Assistance (TBRA Program)

There are two types of TBRA. The first acts as a section 8 voucher to assist with rent. The second is a monthly payment for individuals leaving a NF and is only approved in specific situations on a month to month basis.

Purpose of TBRA HOME & NHT
The TBRA Program is designed to deal with one barrier - housing affordability**.**

1. How Long-Term TBRA Works

- Just like a Section 8 Voucher (Housing Choice Voucher, or HVC).

- The TBRA "coupon" will allow someone to live in approved housing and only pay part of the rent. The remaining portion of the rent will be paid by PHFA using the appropriate source of funds.
- This rental assistance will be available for approximately 2 years and will serve as a bridge to a more permanent subsidy.

NHT TBRA Basics

To be eligible for NHT TBRA, consumers must be:

- At the income level that makes them eligible for the permanent subsidy.
- Transitioning out of nursing home.
- Resident of PA.
- On a waiting list for local Housing Choice Voucher or other subsidized housing.
- Eligible for HCV or subsidized housing.

NHT TBRA Process

- Identify potential applicant and get them on HCV or other subsidized waiting list.
- Download forms from PHFA website.
- Complete PHFA Certification and submit to PHFA along with other required info.
- If eligible, PHFA will send Rental Assistance Packet. Consumer and NHTC then have 60 days to find housing and submit Request for Unit Approval Form to PHFA.
- PHFA will conduct a Housing Quality Standards inspection, review the lease and determine if the rent is reasonable.
- PHFA will calculate the applicant's rent and the TBRA subsidy.
- NHTC helps applicant and the Landlord enter into a lease agreement that includes PHFA lease addendum.
- PHFA and the Landlord will enter into a Rental Assistance contract.

At 11 months: If permanent subsidy has not been found, PHFA will schedule annual inspection and recertification.

At or before 24 months: TBRA subsidy ends and HCV begins **or** consumer moves into subsidized housing.

2. How Short-Term Monthly TBRA Works

- May be available for up to 3 months for someone transitioning from a NF to the community and is reviewed on a case by case basis
- The NHTC must complete the TBRA application and submit to PHFA.
- There are specific instances in which this type of TBRA may be approved:
  - The individual is unable to transition to the selected apartment due to a home modification being incomplete.
  - Durable Medical Equipment has not yet been delivered or set up in the selected apartment.
  - Individual's income has not yet been made available (SSDI, SSI).
  - ISP has not been approved by OLTL.
  - SC has not accepted the HCSIS file.

- Please note that TBRA does not cover the cost of security deposit or application fees. Those fees may be applied for through Waiver (W7334) for Waiver eligible individuals or through SNHTF for those who are Non-Waiver eligible.

811 Project Rental Assistance

The Section 811 Project Rental Assistance (PRA) program is a collaboration between PHFA and DHS to provide extremely low income persons with disabilities access to affordable, integrated, and accessible housing.

811 PRA will provide a project-based rent assistance subsidy. The rental assistance will pay the difference between the amount the tenant can pay affordably and the approved fair market rent for that apartment.

Eligibility
At least one person in the household must be non-elderly (age 18 to 61), disabled, and receiving or be eligible to receive Medicaid (Long Term Services and Supports). The gross household income must be at or below 30% Area Median Income (Extremely Low Income).

Referral Network
The DHS Local Lead Agencies (LLAs) and their stakeholders will conduct outreach, identify potential applicants, screen for eligibility, and refer applicants to vacant apartments.

811 PRA has three priority target groups that includes adults with Autism, intellectual and physical disabilities, serious mental illnesses, and transitional age youth with disabilities. These groups are then prioritized based on the setting the applicant currently lives in:

- Priority 1 - Institutionalized but able to live in the community in permanent supportive housing. This includes, but is not limited to: private and public psychiatric hospitals, nursing facilities and facilities for those with intellectual disabilities.
- Priority 2 - At-risk of institutionalization with no permanent supportive Housing. This includes, but is not limited to: people who are living with caregivers in unstable situations, homeless, people aging out of the Early and Periodic Screening, Diagnosis and Treatment Program with no family supports, and individuals aging out of foster care.
- Priority 3 - Congregate Care Setting and desires to live in community. This includes, but is not limited to: persons in Community Residential Rehabilitation facilities, Long Term Structured Residences, personal care homes and domiciliary care.

Properties
An eligible multifamily property can be any new or existing property funded with federal HOME, and/or Low Income Housing Tax Credit program with at least 5 housing units. Proper-ties must be fully integrated. Units must meet the program criteria for integration, accessibility and access to transportation and services

PA Housing Search

Pennsylvania Housing Finance Agency (PHFA), PA Department of Community and Economic Development (DCED), PA Emergency Management Agency (PEMA), and PA DHS have partnered together to bring http://www.PAHousingSearch.com.

A free service to list and find affordable home and apartments across Pennsylvania: This site is powered by http://www.socialserve.com and helps individuals search for affordable homes and apartments in Pennsylvania and allows landlords to advertise available units.

For more information, go to: http://www.PAHousingSearch.com or call 1-877-428-8844

Other Community Services

In addition to Community Transition Services (CTS) available through HCBS waivers and other state-funded programs such as SNHTF, there are a wide variety of community resources available through various organizations and agencies to help ensure a successful transition.

Public Assistance

The CAO can help determine if individuals are eligible for public assistance. An application for public assistance can be made through the COMPASS website at https://www.compass.state.pa.us/Compass.Web/public/cmphome. Examples of public assistance include:

- Access Card/Medical Assistance
- Cash assistance
- Supplemental Nutritional Assistance Program (SNAP (food stamps))
- Home Maintenance Deduction (if applicable)
- HCBS Waiver services-PA 600
- Low Income Heating and Energy Assistance Program (LIHEAP)

Social Security Office

The Social Security Office can help determine if individuals are eligible for:

- Supplemental Security Income - SSI
- Social Security Disability Income - SSDI
- Retirement payments.

Private Income Payments

Some individuals may be eligible for private income payments like:

- Pension
- Workman's Compensation
- Private Disability Insurance
- Assets and Investments
- Settlements/Insurance

Other Local Agencies

Local agencies can provide additional information or services. Agencies like Centers for Independent Living, Area Agencies on Aging, Office of Vocational Rehabilitation, Office of Deaf and Hard of Hearing, and Local Transportation agencies have staff that is knowledgeable about available services and willing to help individuals access those services.

Churches, YMCAs/YWCAs, charities, volunteer services, the Salvation Army, Goodwill stores, food banks, counseling services and the AARP are just a few of the countless other organizations and services individuals can access.

Chapter 15: Legal Issues

Guardianship

When an individual reaches the age of 18, regardless of any functional limitations or disabilities, s/he has the legal right to make decisions on his/her own behalf. Only a court, after a legal proceeding, may judge an individual to be incapacitated and appoint a guardian to make decisions for him/her. The purpose of this section is to assist you when you describe Pennsylvania's guardianship procedures to persons with disabilities, older adults, their families, service providers, advocates, and friends.

While the appointment of a guardian for a person with limited or impaired mental functioning may in some cases be unavoidable in order to protect the individual's well-being, guardianship proceedings can be costly legal procedures that may be inconsistent with the habitability goal of maximizing a person's independence. Alternatives to guardianship may prove equally effective at a substantially lower emotional and financial cost. Before initiating guardianship proceedings, it is advisable to fully explore the alternatives. The majority of older adults and persons with disabilities live in the community with the assistance of their families or a system of support services without the need for guardians.

The Guardianship Act sets the parameters for what constitutes incapacity and defines an "Incapacitated person" as an adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that he is partially or totally unable to manage his financial resources or to meet essential requirements for his physical health and safety.

Potential signs of incapacity may be:

- Short term memory loss
- Language and communication problems
- Comprehension problems
- Lack of mental flexibility
- Calculation problems
- Disorientation – place, time, or location
- Significant emotional distress
- Delusions
- Hallucinations

When is Guardianship Necessary?

When the alleged incapacitated is unable to evaluate information and communicate decisions in any way and he/she is impaired to the point that financial, physical health and safety needs cannot be met by the impaired party AND there is no system of family or friends available to intervene to meet the needs and protect the impaired party AND there is no previously executed Durable Power of Attorney which can serve as a substitute decision making process for the incapacitated party.

Under what circumstances may a guardian be appointed? A Pennsylvania court may appoint a guardian of the person and/or of the estate for an individual who lives in Pennsylvania and a guardian of the estate for a person who has property in Pennsylvania if it determines after a hearing that the individual is “incapacitated”.

Who may be appointed Guardian?

The court may appoint as guardian any qualified individual, a corporate fiduciary, a nonprofit corporation, a guardianship support agency under Subchapter F (relating to guardianship support) or a county agency. In the case of residents of State facilities, the court may also appoint, only as guardian of the estate, the guardian office at the appropriate State facility. The court shall not appoint a person or entity providing residential services for a fee to the incapacitated person or any other person whose interest’s conflict with those of the incapacitated person except where it is clearly demonstrated that no guardianship support agency or other alternative exists. Any family relationship to such individual shall not, by itself, be considered as an interest adverse to the alleged incapacitated person. For persons residing in state facilities, the guardianship office may be appointed guardian of the estate. In addition, unless no alternative exists, residential service providers will not be appointed as guardian. If appropriate, the court shall give preference to a nominee of the incapacitated person.

What are the Guardians Duties?

It is the duty of the guardian of the person to assert the rights and best interests of the incapacitated person giving due consideration to the incapacitated parties interests and wishes. Guardians of the estate have the duty to act in the best interest of the incapacitated party, to protect the party’s estate and to manage it with an eye to maximizing the assets available to the incapacitated party for as long as possible. Guardians must file reports at least annually with the court regarding the incapacitated parties estate and person. Within 60 days of the death of the incapacitated, or when he/she has recovered his/her capacity, a final report must be filed by the guardian with the court.

What are duties not granted to Guardians? Guardians cannot admit the incapacitated person to an inpatient psychiatric facility or a state center for the mentally challenged.

A cooperative agreement exists between the Department of Aging and each Area Agency on Aging which includes guardianship services and describes appropriate guardianship activities as including the evaluation of older adults as to the appropriateness and degree of guardianship needed, the securing of such guardianships and managing established guardianships as appropriate.

Note: The information in this booklet is not intended to constitute legal advice applicable to specific factual situations.

What are the alternatives to guardianship?

Many people who cannot independently manage their finances seek the assistance of family or friends in money management. These voluntary relationships can often avoid the need for formal guardians. Additionally, habilitation programs can increase the degree to which people can manage their finances, either independently or with assistance of others. Public benefits, such as Social Security Disability and Supplemental Security Income (SSI), can be managed without a guardian through the appointment of a representative payee. Advance planning by families can usually avoid the need for a guardian.

Many aging persons and people with disabilities are able to make decisions concerning many or all of the nonmonetary aspects of their lives without the assistance of a guardian. In some cases, family, friends, and mental health or intellectual development disability service providers can assist in this decision-making process. Guardianship may be unnecessary even if a person is unable to make decisions with the assistance of others. Often existing laws and practices aid in substitute decision-making. For example, medical providers routinely provide medical treatment at the request of families on behalf of the elderly and persons with disabilities, even when there exists a question of whether the individual understands the medical procedure to be undertaken.

If no next-of-kin is available, the Mental Health and Mental Retardation Act of 1966 permits service providers to consent to certain medical treatment on behalf of persons in group homes or other residential facilities.

This provision states: “The director of any facility may in his discretion and with the advice of two physicians not employed by the facility, determine when elective surgery should be performed upon any mentally disabled person admitted or committed to such facility where such person does not have a living parent, spouse, issue, next of kin, or legal guardian as fully and to the same effect as if said director had been appointed guardian and had applied to and received the approval of an appropriate court therefore.” This statute, however, does not permit substituted consent to medical treatment in all cases. For example, it would not permit consent to psychiatric treatment, to AIDS/HIV testing, or to medical treatment when an individual is refusing treatment.

There are circumstances when the appointment of a guardian is unavoidable. However, guardianship proceedings should be initiated only after a problem has been identified for which there is no alternative less restrictive solution. It is generally not advisable to initiate guardianship proceedings simply because a service provider or other professional recommends guardianship or suggests that guardianship is routinely needed for persons with severe disabilities or persons living in mental health or intellectual development disability facilities.

For more information, see Estate Planning for Families of Persons with Disabilities, available free of charge by contacting the Disabilities Law Project at the telephone numbers listed at the end of this booklet or on its web site at www.dlp-pa.org.

How is a guardianship proceeding initiated?

An interested person may file a petition in the Court of Common Pleas, Orphans Court Division in their county for the appointment of a guardian for a person or the person’s estate. The person who files the petition (“petitioner”) must personally serve the person for whom a guardian is sought (“respondent”) with a copy of the petition and written notice of the time, date, and place of the proposed hearing at least 20 days prior to the hearing. The notice must be in large type and simple language. The notice must explain the purpose and seriousness of the proceeding and the rights that can be lost as a result of the proceeding. The notice also must inform the respondent of his/her right to request the appointment of counsel and to have paid counsel appointed, if appropriate. The petition also must give notice to other interested parties, such as family members.

What must the petition include?

All guardianship petitions must be written in plain language and must include the following information:

- the name, age, residence, and post office address of the respondent;

- the names and addresses of the respondent's spouse, parent(s), and presumptive adult heirs;
- the name and address of the person or institution providing residential services to the respondent;
- the names and addresses of other persons or entities that provide services to the respondent;
- the name and address of the person or entity whom the petitioner asks to be appointed as the guardian;
- an averment that the proposed guardian has no interest that is adverse to the respondent;
- the qualifications of the proposed guardian;
- the reasons why guardianship is sought;
- a description of the functional limitations and physical and mental condition of the respondent;
- the steps taken to find less restrictive alternatives; and
- the specific areas of incapacity over which the petitioner requests that the guardian be assigned powers.

If the petitioner seeks appointment of a guardian of the estate, the petitioner must include (in addition to the information listed above), the gross value of the respondent's estate and net income from all sources to the extent known.

Must the respondent be present at the hearing?

If the respondent is in Pennsylvania, he or she must be present at the hearing unless either (a) a physician or psychologist states (under oath) that the person would be harmed by being present, or (b) it is impossible for him or her to be present due to his absence from the Commonwealth. At the request of the respondent or his/her counsel, the hearing may be held at the respondent's residence.

Does the respondent have a right to counsel?

A respondent may hire or retain counsel to represent him/her in a guardianship proceeding. The petitioner has an obligation to determine whether counsel has been retained by or for the respondent and must notify the court at least 7 days prior to the hearing if the respondent does not have counsel. The court may appoint counsel at no cost to the respondent if counsel has not otherwise been retained to represent the respondent. Residents of state psychiatric hospitals and state intellectual development disability facilities must have counsel appointed to represent him/her in guardianship proceedings.

Does the respondent have a right to an independent evaluation?

The respondent may petition the court for the appointment of an expert to perform an independent evaluation as to his/her capacity. The court will order such an evaluation for cause. If the court chooses to order an independent evaluation, it must give due consideration to the evaluator nominated by the respondent.

What does a court consider in determining whether to appoint a guardian?

Under the guardianship statute, "'[t]he court has the power to place total control of a person's affairs in the hands of another. This great power creates the opportunity for great abuse.'" As such, the petitioner must establish by clear and convincing evidence that the respondent is incapacitated. In determining whether the respondent is incapacitated, the court must consider, among other things,

the nature of the respondent's disability and the extent of the respondent's capacity to make or communicate decisions.

To prove incapacity, the petitioner must present testimony from an individual qualified by training and experience in evaluating individuals with the respondent's alleged incapacities that establishes the nature and extent of the respondent's incapacities and disabilities; the respondent's mental, emotional, and physical condition; the respondent's adaptive behavior; and the respondent's social skills.

In addition, the petitioner must present evidence regarding:

- The services being utilized to meet the essential requirements for the respondent's physical health and safety;
- The services being utilized to manage the respondent's financial resources;
- The services being utilized to develop or regain the respondent's abilities;
- The types of assistance required by the respondent;
- Why no less restrictive alternatives would be appropriate; and
- The probability that the extent of the person's incapacities may significantly lessen or change.

In determining whether a respondent is incapacitated, the court must also make specific findings concerning the respondent's need for guardianship services in light of existing alternatives, such as the availability of family, friends, and other supports to assist the respondent in making decisions, and in light of the existence of any advance directives such as durable powers of attorney or trusts.

If the court determines that the respondent is incapacitated and needs guardianship services, it must then determine:

- Whether the guardianship should be limited based upon the nature of the respondent's disability and his/her capacity to make and communicate decisions; and
- The duration of the guardianship.

The court will prefer to appoint a limited guardian if the respondent is partially incapacitated, but needs guardianship services. The court may appoint a plenary guardian of the person and/or estate only upon specific findings that the respondent is totally incapacitated and in need of plenary guardianship services.

What are the powers of a limited guardian?

If the court appoints a limited guardian, it must identify the powers of the guardian and those powers must be consistent with the court's finding of the respondent's limitations. The partially incapacitated person retains all legal rights other than those designated by the court's order as areas over which the limited guardian has power.

The powers of a limited guardian of the person may include:

- Providing general care, maintenance, and custody of the partially incapacitated person;
- Designating the partially incapacitated person's place of residence;
- Assuring, as appropriate, that the partially incapacitated person receives appropriate training, education, medical and psychological services, and social and vocational opportunities;

- Assisting the partially incapacitated person in the development of maximum self-reliance and independence; and
- Providing the required consents or approvals on behalf of the partially incapacitated person.

In appointing a limited guardian of the estate, the court (in addition to outlining the guardian's specific powers and authority) must specify the portion of assets or income over which the limited guardian of the estate has assigned powers or duties.

What are the duties of a guardian of the person?

The duties of a guardian of the person include: (1) assertion of the rights and interests of the incapacitated person; (2) respect for the wishes and preferences of the incapacitated person to the greatest extent possible; (3) participation, where appropriate, in the development of a plan of supportive services to meet the person's needs; and (4) encouragement of the incapacitated person to participate to the maximum extent of his or her abilities in all decisions that affect him/ her, to act on his/her behalf when he or she is able to do so, and to develop or regain his/her capacity to manage his/her personal affairs to the maximum extent feasible.

Unless expressly included in the court's order based upon specific findings, a guardian (or emergency guardian) may not have the power (1) to consent on behalf of the incapacitated person to an abortion, sterilization, psychosurgery, electroconvulsive therapy, or removal of a healthy body organ; (2) prohibit the marriage or consent to the divorce of the incapacitated person; and (3) consent on behalf of the incapacitated person to the performance of any experimental biomedical or behavioral medical procedure or to the participation in any biomedical or behavioral medical experiment

In addition, the court may not grant to a guardian any powers that are controlled by another statute, including the power to admit the incapacitated person to an inpatient psychiatric facility or state center for persons with intellectual disabilities or to consent to the termination of the incapacitated person's parental rights.

What are the duties of a guardian of the estate?

The Pennsylvania guardianship statute details a number of matters that may be handled by an appointed guardian of the estate, including insurance, continuation of a business, investments, and sale of personal property. In exercising those duties, a guardian of the estate must use the standard of care that a person of ordinary prudence would practice in the care of his own estate. A guardian must manage the estate exclusively for the benefit of the incapacitated person and is not permitted to obtain any undue profit or advantage from his position and may not place himself in a position in which his personal interests are in conflict with those of the incapacitated person.

What information must the court provide if it appoints a guardian?

If the court determines that the respondent is incapacitated and appoints a guardian, it must assure that the respondent is informed of his/her right to appeal and his/her right to petition to modify or terminate the guardianship.

What are the procedures for the appointment of an emergency guardian?

A person may file a petition for appointment of an "emergency guardian" for persons who are present in Pennsylvania and who need the immediate appointment of a guardian. The court will appoint an

emergency guardian if, after a hearing, it finds by clear and convincing evidence that (1) the respondent is incapacitated; (2) the respondent needs a guardian; and (3) failure to appoint a guardian will result in irreparable harm to the respondent's person or estate. The court must specify the powers, duties, and liabilities of that guardian in its order. The appointment of an emergency guardian of the person can be in effect no longer than 72 hours. If the emergency continues, the order may be extended for 20 days from the date of the expiration of the initial emergency order. After the expiration of the extension, the petition must institute a full guardianship proceeding in order to continue the guardianship. An emergency guardianship of the estate may not exceed 30 days, at which time the petitioner must initiate a full guardianship proceeding.
The court must, to the extent feasible under the circumstances, adhere to all of the procedures outlined above -- including those relating to the appointment of counsel for the respondent -- in a proceeding for the appointment of an emergency guardian.

What reports must a guardian file?

Within one year of the appointment and at least once annually thereafter, a guardian of the person must file with the court a report attesting to the following:

- The current address and type of placement of the incapacitated person;
- Any major medical or mental problems experienced by the incapacitated person;
- A brief description of the incapacitated person's living arrangements and the social, medical, psychological and other support services he is receiving;
- The opinion of the guardian as to whether the guardianship should continue, be terminated or modified, and the reasons for that opinion;
- The number and length of times the guardian visited the incapacitated person during the past year.

A guardian appointed for an incapacitated person's estate must file with the court within one year of his appointment and on an annual basis thereafter a report attesting that:

- The incapacitated person's current principal and how it is invested;
- The incapacitated person's current income;
- The expenditures of principal and income since the prior report; and
- The needs of the incapacitated person for which the guardian has provided since the last report.

How can a guardianship order be terminated or a guardian removed?

An incapacitated person, the guardian, or any interested person may petition the court for a review hearing or a court on its own may decide to hold a review hearing. A review hearing may be used to: (1) assert that there has been a significant change in the person's capacity so that guardianship is no longer necessary (or a more limited guardianship order is appropriate); (2) assert that the guardian's failure to perform his duties; or (3) assert that the guardian has failed to act in the incapacitated person's best interests, including a failure to honor his/her preferences to the fullest extent possible.

In a review hearing, the incapacitated person has all of the rights he/she would have at an initial guardianship hearing (including the right to be present and to seek appointed counsel). The incapacitated person may also be represented by counsel of his/her choosing at any review hearing. A person need only prove by a fair preponderance of the evidence that he/she has regain capacity so

as to no longer need guardianship while the party advocating continued guardianship has the heavier burden of showing by clear and convincing evidence that the person remains incapacitated.

Conclusion

Pennsylvania's guardianship law was designed to (1) permit incapacitated persons to participate as fully as possible in all decisions that affect them; (2) assist such individuals to meet the essential requirements for their physical health and safety, to protect their rights, to manage their financial resources, and to develop or regain their abilities to the maximum extent possible; and (3) to accomplish these objectives through the use of the least restrictive alternative. The two most important features of the Pennsylvania guardianship law are: (1) that it permits the appointment of limited guardians to ensure that only those restrictions necessary in the particular circumstances are imposed, and (2) that it provides for certain procedural safeguards to prevent the unwarranted appointments of guardians. Despite these features, guardianship should be viewed as the option of last resort and used only if other alternatives do not provide an adequate solution.

Chapter 16: Protective Services

Pennsylvania's Older Adults Protective Services Act (OAPSA) provides that older adults, and Adult Protective Services (APS) for individuals 18-59 years old, who lack the capacity to protect themselves and are at imminent risk of abuse, neglect, exploitation or abandonment shall have access to and be provided with services necessary to protect their health, safety and welfare. It is not the purpose of the Act to place restrictions upon the personal liberty of incapacitated older adults, but should be liberally construed to assure the availability of protective services to all older adults in need of them. Such services shall safeguard the rights of incapacitated older adults while protecting them from abuse, neglect, exploitation and abandonment. The Act also provides for the detection and reduction, correction or elimination of abuse, neglect, exploitation and abandonment, and to establish a program of protective services for older adults in need of them.

The most up-to-date information can be found at the following:

A copy of the DHS OLTL Bulletin on Critical Incident Reporting can be found at the link below: http://www.dhs.pa.gov/publications/bulletinsearch/bulletinsearchresults/index.htm?po=OLTL#.Vw_oLq32bSd

Reports of abuse of persons ages 18 and above can be made at the link below: http://www.dhs.pa.gov/citizens/reportabuse/dhsadultprotectiveservices/#.Vw_n0632bSc

Act 70 for Adult Protective Services:
http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2010&sessInd=0&act=70

Older Adults Protective Services Act:
http://www.pacode.com/secure/data/006/chapter15/chap15toc.html

Report Of Need form:
http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_167248.pdf

Local Area Agencies on Aging:
http://www.aging.pa.gov/local-resources/Pages/AAA.aspx

55 Pa. Code Chapter 52 Regulations: http://www.pacode.com/secure/data/055/chapter52/chap52toc.html

Enterprise Incident Management:
https://www.hhsapps.state.pa.us/eim/

Adult Protective Services FAQ:
http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_199869.pdf

Chapter 17: Nursing Facility Resident Rights

Federal and state laws guarantee quality care to nursing facility residents, ensuring a legal right to privacy, dignity, quality of life, and protection from abuse.

A nursing facility resident has the right to:

- Be informed in writing of his/her rights and the policies and procedures of the facility
- Know about services and charges
- Know about his/her medical condition
- Participate in his/her plan of care, including the right to refuse treatment
- Choose your own physician and use the pharmacy of your choice
- Have personal and medical records be confidential
- Manage own personal finances
- Privacy, dignity, respect
- Use of his/her own clothing and possessions
- Be free from mental, physical and sexual abuse, exploitation, neglect and involuntary seclusion
- Be free from restraints
- Voice grievance without retaliation
- Not be transferred or discharged against his/her will, except for medical reasons, his/her own welfare or that of another resident, non-payment, or if the facility ceases to operate
- Access to nursing facilities

Click on the link to access a "Know Your Rights as a Nursing Home Resident" Booklet. http://www.aging.state.pa.us/aging/lib/aging/Know_Your_Rights_as_a_Nursing_Home_Resident.pdf

If a resident feels that his/her rights have been violated or he/she has concerns over his/her care, the resident may wish to speak to the facility's administrator or a staff member who is in charge.

In some cases the resident may want to consult with the **Long-Term Care Ombudsman** or file a complaint with the **Department of Health.**

To locate the Ombudsman in the area, the resident can contact the Area Agency on Aging, or call the State Long-Term Care Ombudsman Office at (717) 783-8975.

The Department of Health Long Term Care Facility Complaints toll-free hotline is 1-800-254-5164.

Power of Attorney

What is a Power of Attorney?

A Power of Attorney (POA) is a written document that allows an older Pennsylvanian to appoint someone to become his/her agent in order to give the person authority to act on his/her behalf. When the principal appoints an agent, the person must exercise his/her authority for the benefit and in accordance with the wishes of the principal.

Whatever decisions and business transactions that an agent makes on behalf of the principal will become just as binding as if the principal made them themselves. Therefore it is important that the principal choose an agent they can trust.

Why would someone want to make a Power of Attorney?
A POA allows an older Pennsylvanian to appoint someone he/she trusts to make decisions and complete transactions on your behalf. There may be many reasons why the principal would like someone else to act for him/her. Some examples include times when they are traveling and are unable to be present to sign documents or when they believe that someone else is better qualified to make a certain type of decision. They may wish to have his/her POA become effective only in the event that they become too disabled or lack capacity to make his/her own decisions. This is called a Springing POA. Having a POA in place in advance of incapacity may allow them to avoid having a guardian appointed by a court. In the event that a guardian is appointed at a later time, the agent will be accountable to the guardian in the same way he or she is accountable to the principal.

What authority can a principal delegate to his/her agent?
An older Pennsylvanian may empower his/her agent to handle many different facets of his/her affairs. In order to do this, he/she must specify what powers they wish to allow his/her agent to have in his/her document. Examples of the powers that he/she may give to his/her agent are the powers to conduct financial and property transactions, authorize medical care, create a trust, and apply for and receive government benefits. He/she may delegate one or more of the powers. The powers that they specify in their POA are the only powers that his/her agent may exercise on his/her behalf. He/she may designate more than one agent to handle decisions and transactions jointly or different agents to handle different powers. He/she may also nominate who he/she would like to have as a guardian in the event that they need one at a future time.

When will a Power of Attorney become effective and how long will it last?
As noted above, an older Pennsylvanian may specify in his/her POA when it becomes effective, including a future date, such as when he/she will be away on a trip, or upon some specific event, such as his/her inability to make decisions for himself/herself due to mental incapacity. If they do not specify a time, his/her POA will become effective immediately when they sign and date it. Depending on the powers that they delegate, his/her agent may also be required to sign and date it before it will become effective. A POA is presumed durable, meaning that it continues to be effective until a time that he/she specifies in the POA, or until he/she revokes his/her POA, even if he/she becomes incapacitated. He/she can choose to make his/her POA non-durable, meaning that it will terminate if he/she becomes too incapacitated to make decisions for himself/herself.

How can someone terminate their Power of Attorney?
A durable POA can be terminated either by specifying a termination date in the document or at any time by giving notice to the older Pennsylvanian's agent of his/her revocation. It will automatically terminate when his/her agent receives notice of his/her death. If he/she designates his/her spouse as his/her agent, and at a later time he/she or his/her spouse file for divorce, the POA will terminate upon the filing unless the POA specifies otherwise. In addition to these methods of termination, a non-durable POA will also automatically terminate when his/her agent receives notice of his/her incapacity. If a guardian is appointed after he/she makes a durable POA, the guardian may revoke or amend his/her POA.

How can someone make a Power of Attorney?
They must be an adult and be able to make an informed decision regarding giving another person the authority to make decisions on his/her behalf. He/she must sign the POA. If he/she signs by mark or

has someone else sign for him/her, he/she must have two witnesses over the age of 18 sign also. Depending on the kind of powers he/she delegates to the agent, his/her agent may also be required to acknowledge the responsibilities of being his/her agent by signing the document. His/her POA must contain very specific language to be effective. Therefore always suggest that consumers consult an attorney in order to be sure that his/her POA reflects his/her wishes.

For more information, you can contact the intake system of Disability Rights Network of Pennsylvania (DRN) at 800-692-7443 (voice) or 877-375-7139 (TTY).© July 2007. Disability Rights Network of Pennsylvania.

Prepared by:
Disability Rights Network of Pennsylvania
http://www.drnpa.org

1414 N. Cameron Street, Suite C
Harrisburg, PA 17103
1-800-692-7443 [Voice]
1-877-375-7139 [TTY]
drnpa-hbg@drnpa.org [Email]
717-236-0192 [Fax]

Resources and Additional Contacts

General Resource Links

Aging and Disability Resource Center (The Link)
http://www.aging.pa.gov/local-resources/pa-link/Pages/default.aspx#.VyD5CHrD8kI

American Public Transportation Association
http://www.apta.com/Pages/default.aspx

Commonwealth of Pennsylvania Website
www.state.pa.us

COMPASS (apply for benefits provided by many human services programs)
https://www.compass.state.pa.us/Compass.Web/public/cmphome

Housing and Social Services Resources from PHFA Website
http://www.phfa.org/applications/housing_services_resources.aspx

Pennsylvania Department of Education
http://www.education.pa.gov/Pages/default.aspx#.VyD5d3rD8kI

PHFA Homeownership Programs
www.phfa.org

Pennsylvania Public Transportation Association
http://www.ppta.net/index.html

Property Tax/Rent Rebate Program
www.revenue.pa.gov

Social Security Administration
www.ssa.gov

Elder Resources

Pennsylvania Association of Area Agencies on Aging
www.p4a.org

PA Behavioral Health and Aging Coalition
www.olderpa.org

Pennsylvania Department of Aging
www.aging.pa.gov

Resources for People with Disabilities

Americans with Disabilities Act - ADA Technical Assistance Centers
http://www.ada.gov/

Autism – Paula Kluth: Toward More Inclusive Classrooms and Communities
http://www.paulakluth.com/

Deaf, Blind, Deaf-Blindness National Association for the Deaf
http://www.nad.org/

Disability.gov: U.S. federal government website for information on disability programs and services nationwide
www.disability.gov

Disability Rights Pennsylvania (formerly Disability Rights Network of Pennsylvania)

- Harrisburg 1-800-692-7443 (1-877-375-7139 TDD)
- Philadelphia 1-215-238-8070 (1-215-789-2498 TDD)
- Pittsburgh 1-412-391-5225 (1-412-267-8940 TDD)

Intellectual Disabilities Services
http://www.dpw.state.pa.us/fordisabilityservices/intellectualdisabilitiesservices/index.htm

Mental Health and Substance Abuse
www.networkofcare.org

Non-Verbal Communication - Communication matrix for parents and professionals
http://www.communicationmatrix.org/

PA Council on Independent Living (PCIL)
http://www.pasilc.org

RJ Cooper and Associates Software and Hardware for People with Disabilities
http://www.rjcooper.com/

World Institute on Disability
https://wid.org/

Emergency Preparedness and Recovery

American Red Cross
www.redcross.org

Disaster Assistance
www.disasterassistance.gov

Federal Emergency Management Agency
www.fema.gov

Pennsylvania Emergency Management Agency
www.pema.pa.gov

Employment Resources

Job Search – PA Career Link
www.pacareerlink.com

PA Department of Labor and Industry: PA Office of Vocational Rehab (OVR)
http://www.portal.state.pa.us/portal/server.pt/community/vocational_rehabilitation/10356

PA Medical Assistance for Workers with Disabilities
http://www.dhs.pa.gov/citizens/healthcaremedicalassistance/medicalassistancebenefitsforworkerswithdisabilities/#.V2BG1632YkI

Housing Resources

Housing Alliance of Pennsylvania (HAP):
http://www.housingalliancepa.org/

Lehigh Valley CIL, "Landlords for All" program
http://www.lvcil.org/landlord.aspx

Local Housing Options Teams (LHOTs)
http://www.pahousingchoices.org/housing-resources/local-housing-options-teams/

PA Assistive Technology Foundation Loans
http://www.patf.us/

PA Community Action Association of Pennsylvania
http://www.thecaap.org/

PA Housing Finance Agency:
http://www.phfa.org/
PA Housing Search (TBRA)
www.pahousingsearch.com

PA Residential Owners Association
http://www.proassoc.org/cgi-bin/PROAOrgs.pl

PATF/SDHP Housing Resources
https://patf.us/housing-resources/

Rebuilding Together (Non-Profit Volunteers) - Home Modifications & Home Repairs
http://www.togetherwetransform.org/find-your-local-affiliate

Self-Determination Housing Project of Pennsylvania, Inc
www.sdhp.org

Technical Assistance Collaborative, Inc
www.tacinc.org

US Department of Agriculture - Rural Development: Rural Housing Repair
http://www.rd.usda.gov

US Department of Housing and Urban Development
www.hud.gov

US Department of Housing and Urban Development
HUD 202 and 81 Properties in PA
http://www.hud.gov/offices/hsg/mfh/hto/state/pa.pdf

US Department of Veterans Affairs (VA): Specially Adapted Housing (SAH) Grant
http://www.benefits.va.gov/homeloans/sah.asp

US Internal Revenue Service: Tax Credit/Deduction
http://www.irs.gov/publications/p907/ar02.html

Other Resources

Annual Credit Report
https://www.annualcreditreport.com/index.action

Architectural and Transportation Barriers Compliance Board
http://www.access-board.gov/sec508/508standards.pdf

Commission on Accreditation of Rehabilitation Facilities (CARF):
http://www.carf.org/home/

Consumer Credit Counseling Services
http://www.credit.org/cccs

Federal Trade Commission - Opt Out Junk Mail
http://www.ftc.gov/

Govt Mortgage Assistance - Don't Wait - Act Today
http://www.makinghomeaffordable.gov/Pages/default.aspx

The Gray Center of Social Learning and Understanding
http://thegraycenter.org/

Help in PA – Health & Human Services Portal
https://www.health.pa.gov/My%20Health/Pages/Help-in-Pa---List-of-Counties.aspx

Joint Commission on Accreditation of Healthcare Organizations (JCAHO):
http://www.jointcommission.org/

National Center for Cultural Competence
http://nccc.georgetown.edu/

National “Do Not Call” Registry
https://www.donotcall.gov/

Obtaining a Photo Identification Card
http://www.dmv.pa./driverLicensePhotoIDCenter/obtainingPhotoID.shtml

Pacer Center ADA Q& A Health Care Providers
http://www.pacer.org/publications/adaqa/health.asp

PA Attorney General Office
http://www.attorneygeneral.gov/SplashPage.aspx

PA Department of Aging Ombudsman
http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616640&mode=2

PA Department of Health - Nursing Homes:
http://www.dsf.health.state.pa.us/health/cwp/browse.asp?a=188&bc=0&c=35675&healthPNavCtr=|&TNID=4672#4672

PA Department of Labor and Industry
www.dli.pa.gov

PA Low-Income Home Energy Assistance Program (LIHEAP)
http://www.dhs.pa.gov/foradults/heatingassistanceliheap/index.htm

Pennsylvania Association of Housing and Redevelopment Agencies (PAHRA):
http://pahra.org/

Pennsylvania Self Advocacy and Resources:
http://www.par.net/Advocacy/SelfAdvocacy.aspx

Social Security Application
http://www.ssa.gov/online/ss-5fs.pdf

Start Your Military Service Record (DD Form 214) Request
http://www.archives.gov/veterans/military-service-records/

Teaching Pre-Linguistic communication
http://nationaldb.org/NCDBProducts.php?prodID=118

Veteran’s Benefits and Outreach
www.va.gov

APPENDIX A

NHT Program MFP Checklist: (insert link)

APPENDIX B

Medical Evaluation Form (MA 51):
http://www.dhs.pa.gov/cs/groups/webcontent/documents/form/s_002559.pdf

APPENDIX C

HCBS Eligibility Form (PA 1768):
http://www.dhs.state.pa.us/cs/groups/WebContent/documents/Form/S_002695.pdf

APPENDIX D

Freedom of Choice Form: http://www.dhs.pa.gov/cs/groups/public/documents/document/c_078848.pdf

APPENDIX E

MFP Informed Consent Form/ Quality of Life Survey:
http://www.emarketplace.state.pa.us/FileDownload.aspx?file=RFP%2007-14/Solicitation_27.pdf

APPENDIX F

Individual Service Plan (MA 546): http://www.dhs.pa.gov/cs/groups/public/documents/document/c_078849.pdf

APPENDIX G

NHT Funding Request Form: (insert link)

APPENDIX H

Service Provider Choice For: http://www.dhs.pa.gov/cs/groups/public/documents/document/c_078851.pdf

APPENDIX I

PA IEB Referral Form: http://www.dhs.pa.gov/citizens/longtermcareservices/ieb/

APPENDIX J

SNHT Funding Requests	CTS Waver Funding Requests
NHT Program services and requests for services covered under Special NHT funding Community Transition services mirrors the CTS services under the waiver programs for individuals that are: • Not MA eligible in the community • MA eligible individuals that are not waiver eligible • MA eligible individuals that are waiver eligible but requested necessary services exceed the waiver limits	**Waiver services that can assist with NHT transitions** If individual is waiver eligible, necessary services: • Must first be accessed through the waiver, See Codes Below. • If service amounts exceed the waiver limit, request may be submitted for SNHTF. • CTS Waiver limit of $4,000.00
Reviewed by NHT staff for approval. Final decision forwarded to Agency. Also shared with Waiver staff if applicable. SNHT funding under the NHT program includes: • Home adaptations/modifications • Equipment (DME) • On-going services • Stranded Cost • Other – Must Specify - This section is for services not specified above such as food or other items not covered by waiver. **Maximum food allowance is $200/mo**	Reviewed by NHT staff for approval. Final decision forwarded to Agency and notice sent to the Waiver staff. CTS Waiver limit of $4,000.00 includes: • W7332 - Essential Furnishing • W7333 - Moving Expenses • W7334 - Security Deposit* • W7335 - Specific one time set-up fees • W7336 - Personal & Environmental H&S assurances **Note:** Necessary CTS waiver service(s) that exceeds the $4000 waiver limit should be requested under the **SNHTF** column.
***Important:** Security Deposit funding request that is required to obtain a lease on an apartment or house. Rent is not covered by the waiver nor can SNHTF be used for rent.	
Home adaptations or modifications for non-MA eligible individuals should be submitted to SNHTF. Requested services for home adaptations or modifications for waiver eligible participants that exceeds the waiver cap can be submitted to SNHTF – but only for the amount that exceeds the waiver limit. **Note:** Home adaptations/modifications for individuals enrolled in the waiver should be first accessed through the waiver program.	Some of the Waiver programs do not have environmental modifications. In this case, AAA or NHT partner can request SNHT funding if the modification is deemed necessary for transition. Some waivers have a cap on modifications. If service amount exceeds the cap, AAA or NHT partner can request SNHT funding to cover amount necessary over cap.

Requests for specialized equipment/DME should be submitted for SNHTF when it is not covered by third party, Medicare, Medicaid (State Plan/Fee Schedule) or waiver program.	Waiver covered specialized DME: State plan and third party payers should be accessed for coverage of DME before billing waiver. SNHTF funding may be requested if DME is not covered by waiver.
Essential household set-up includes food and/or other items not covered by the waiver. **Note:** Maximum food allowance is $200.00/mo.	The $4,000.00 of CTS waiver funds is a total for one participant over a lifetime and can be used to assist in more than one transition – but only up to the lifetime total amount of $4,000.00.
On-going services are for a maximum allowance of six months. **Note:** Agency guarantees to cover services at the conclusion of the six month term.	SNHTF can be requested if services for the waiver eligible participant exceed the $4,000.00 limit.
Stranded costs: Transition expenses paid, but the consumer did not transition. **Note:** Agency will need to explain why the consumer did not transition.	**Important:** Refer to the specific waiver for a list of covered services (billing codes).
Essential Furnishings	
• Not MA eligible in the community • MA eligible but not waiver eligible • Waiver eligible but cost exceeds waiver limits*	• Enrolled into OLTL HCBS Waiver • W7332 • Costs not to exceed waiver limit - $4,000 • Provide detailed list
Moving Expenses	
• Not MA eligible in the community • MA eligible but not waiver eligible • Waiver eligible but cost exceeds waiver limits*	• Enrolled into OLTL HCBS Waiver • W7333 • Costs not to exceed waiver limits - $4,000
Other – Must Specify	
• Not MA eligible in the community • MA eligible but not waiver eligible • Waiver eligible but not covered by waiver • Waiver eligible but cost exceeds waiver limits* • **Example** – Food ($200 maximum per mo)	• Not covered by the waiver program
Personal and Environmental Health & Safety Assurances	
• Not MA eligible in the community • MA eligible but not waiver eligible • Waiver eligible but cost exceeds waiver limits*	• Enrolled into OLTL HCBS Waiver • W7336 • Costs not to exceed waiver limits - $4,000
Security Deposits	
• Not MA eligible in the community • MA eligible but not waiver eligible • Waiver eligible but cost exceeds waiver limits* • SD that is required to obtain a lease on an apartment or house - SNHTF may <u>not</u> be used for rent	• Enrolled into OLTL HCBS Waiver • W7334 • Costs not to exceed waiver limits - $4,000 • SD that is required to obtain a lease on an apartment of house - Rent is not covered by the waiver

Specific One Time Set-Up Fees or Deposits	
• Not MA eligible in the community • MA eligible but not waiver eligible • Waiver eligible but cost exceeds waiver limits*	• Enrolled into OLTL HCBS Waiver • W7335 • Costs not to exceed waiver limits - $4,000
Stranded Cost	
• Transition expenses approved and paid, but consumer did not transition • Must explains reason for not transitioning	• Not covered by the waiver program

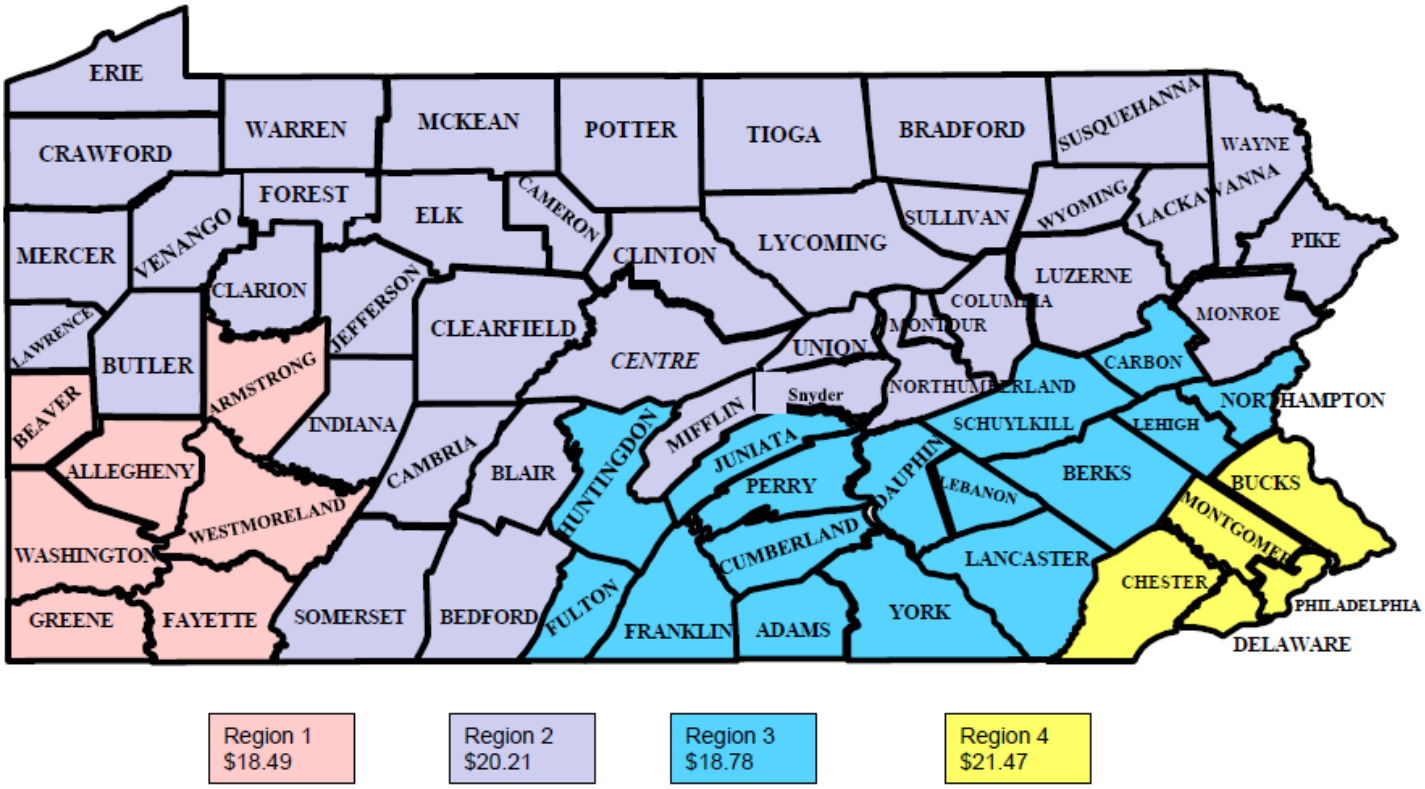
Request SNHTF for only the amount that exceeds the waiver limit

Equipment (Specialized DME): These are waiver services for participants enrolled in OLTL HCBS Waiver and are reviewed through the normal ISP review process under the waiver. State Plan, Medicare and Third Party payers must be accessed first. Service costs cannot exceed the waiver limits and cost cap may apply. Refer to the waiver for details. SNHTF may be requested if the service is not covered by a waiver/third party payer source or when cost exceeds waiver limits – if cost cap applies.
Home Adaptations & Modifications: These are waiver services for participants enrolled in OLTL HCBS Waiver and are reviewed through the normal ISP review process under the waiver. Service costs cannot exceed the waiver limits and cost cap may apply. Refer to the waiver for details. Some waiver programs do not have these services. In these cases, SNHTF may be requested if the service is deemed necessary for transition or when cost exceeds waiver limits – if cost cap applies.

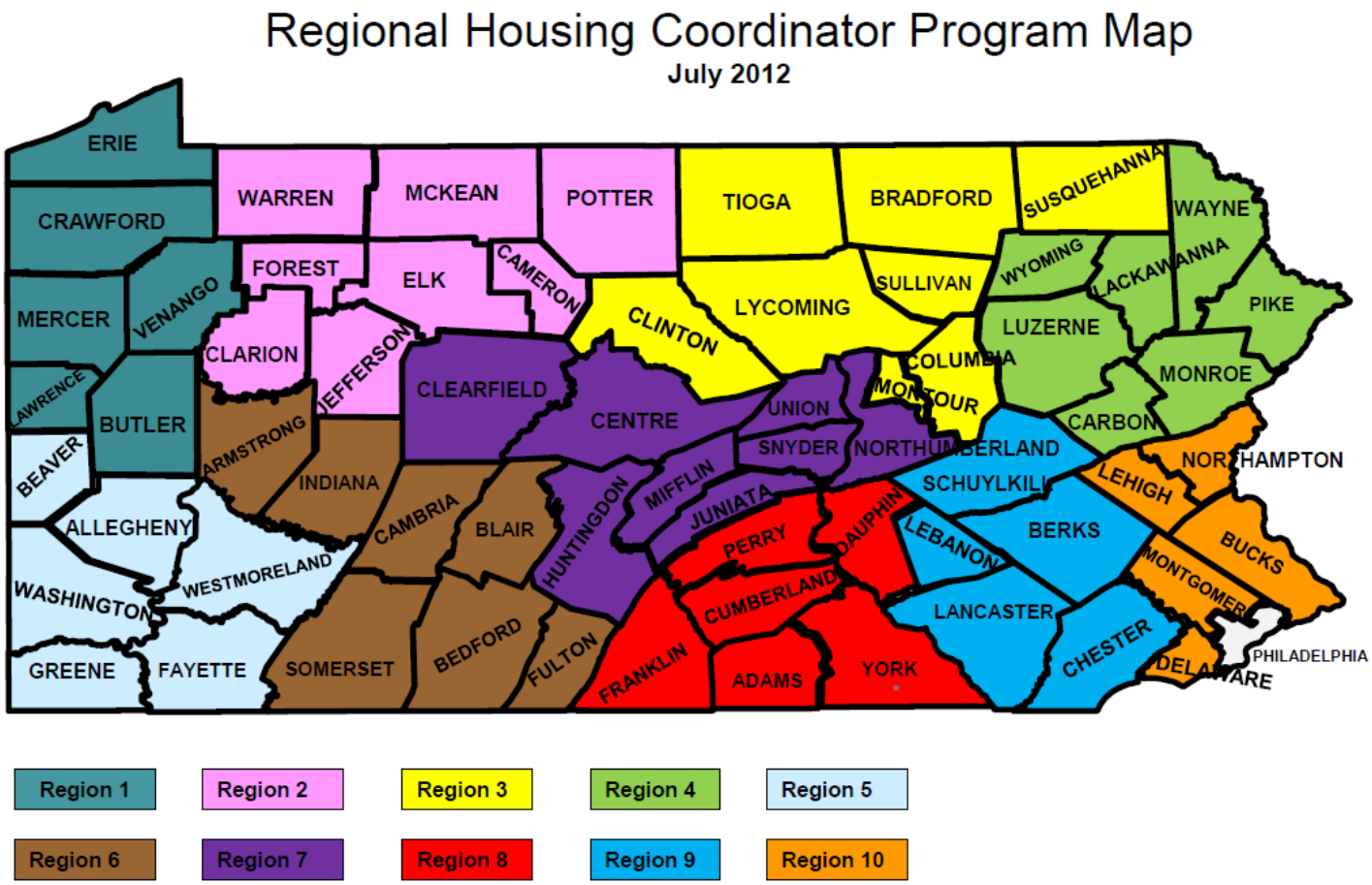
APPENDIX K

Regional Rates for W7337 / NHT 01

October 1, 2016



APPENDIX L



Link: http://www.sdhp.org/rhc-map-and-contacts/