

[Request for Funding](#)

About Community Transition Services

Community Transition Services (CTS) are available through the OLTL Waiver and/or NHT Programs. CTS were implemented to facilitate an expedited process of relocating individuals from nursing facilities to the home and community.

CTS are one-time expenses for individuals who make the transition from an institution to their own home, apartment or family/friend living arrangement. CTS funds may be used to pay for necessary expenses for an individual to establish his/her basic living arrangement and move into that arrangement. CTS are needs based, and furnished only to the extent (1) that they are reasonable and necessary as determined through the Individual Service Plan (ISP) or Community Living Plan development process and (2) the individual is unable to meet such expense or the service cannot be obtained from other sources.

[CTS must be pre-authorized and included in the waiver participant's initial ISP or the participant's NHT service plan for SNHTF/](#)

NHT Funding Request Form

Purpose of NHT Funding Request form: To collect information necessary to determine assistance to consumers who may otherwise be ineligible or not qualify for services and resources, but require transition services/items to successfully relocate. CTS is the funding source of last resort. All third party, community programs/ resources must be pursued before requesting CTS. Individuals who cannot access waiver CTS may be eligible for Special Nursing Home Transition Funds (SNHTF).

Process for submission: Start planning for the consumer's needs once they have made an informed decision to transition to ensure everything is in place at the time of the discharge. Applications need to be submitted a minimum of 10 business days prior to the consumer leaving the facility. Consider the time it will take to get the service or item in place when submitting a request. Allow for enough time for a response and the service or item to be in place before the consumer is discharged. The time frame will vary based on the service or item needed. Email the completed template to ra-transitionfunding@pa.gov. Indicate **Funding Request** in the subject line.

Note: To avoid delays, please be sure that the form is complete and includes all required information.

Process for review: NHT OLTL staff will review all information submitted and contact the submitting agency to approve or deny the request or to obtain additional documentation within 7 business days of submitting the request. If additional information is requested, 7 business days is allotted for a response. **Note:** Untimely responses could result in denials. Exceptions may be made for extraordinary cases.

**** IMPORTANT ****

[Receipts must be kept on file for audit purposes and could be requested as proof of purchase](#)

***** Click On The Highlighted Boxes To Insert Information *****

Type of Request:

SNHTF

CTS

or

BOTH (SNHTF and CTS)

Enrolling into OLTL Waiver - Name of Waiver: Choose an item.

Consumer Information:

Consumer's Name: [redacted]
Social Security Number: [redacted]
Date of Birth: [redacted]
MA ID Number (if applicable): [redacted]
Name of Nursing Facility (NF): [redacted] County location of NF: [redacted]
County where consumer will reside in the community: [redacted]
Date of Admission to the NF: [redacted]
Anticipated discharge date from the NF: [redacted]

Agency Enrollment Information: AAA - NHT Provider - Enrollment Agency

Date of Submission: [redacted]
Agency submitting request: [redacted]
Agency Contact Person: [redacted]
Email: [redacted]
Telephone: [redacted] Extension: [redacted]

Other Agencies: *Please list all other agencies, contact name and phone number that are working with the consumer to transition and/or providing other services and supports*

1. [redacted]
 2. [redacted]
 3. [redacted]
 4. [redacted]
 5. [redacted]
-

Financial Information: *Please respond below:*

Monthly Income: \$ [redacted]

Income Source: Choose an item.

If the response to Income Source is other, please specify: [redacted]

Status of Eligibility for Services in the Community - *Please check all that apply and describe the reason why the consumer is not able to access CTS through any of the waivers or funding through*

other HCBS programs (LTCAAP [known as the LIFE Program], Family Caregiver, OPTIONS and Act 150) to cover transition costs.

- Not eligible for Medicaid in the community. Describe: _____
- NFI** - Assessed by AAA and determined to be NF ineligible. Describe: _____
- No OPTIONS funding available. Describe: _____
- On a waiting list - Where is consumer on the waiting list? _____
- Enrolling into OLTL Waiver which **does not** have CTS funding. Name of waiver: _____
- NFCE** - Individual is NF clinically eligible and waiver ineligible. Describe: _____
- Other – Not specified above: Describe: _____

Request for Community Transition Services (CTS) funding - Please check all that apply:

The specific waiver CTS are one-time expenses not to exceed \$4000 per participant and to be billed using the appropriate billing code (listed below) for each specific category. The five categories of services may not exceed the \$4000 limit when all categories are added together and are being accessed through the waiver. The \$4000 limit is the total for one individual over a lifetime and can be used to assist in more than one transition.

***Note:** SNHTF may be requested if the participant is not waiver eligible or when the necessary CTS services needed exceed the \$4000 limit after pursuing third party and community/ local resources. All CTS costs exceeding the \$4000 limit should be requested below through *SNHTF* (after pursuing third party funding community/ local resources).

	<i>Funding request through:</i>	
	<u>Waiver</u>	<u>*SNHTF*</u>
<input type="checkbox"/> Essential furnishings to establish basic living arrangements (bed, dining table and chairs, eating utensils and food preparation items)		
<u>Estimated Cost:</u>	\$ _____	\$ _____
<u>W7332</u> - Description of item/services: _____		
<input type="checkbox"/> Moving expenses required to occupy a living arrangement		
<u>Estimated Cost:</u>	\$ _____	\$ _____
<u>W7333</u> - Description of item/services: _____		
<input type="checkbox"/> Security deposits that are required to obtain a lease on an apartment or house		
<u>Estimated Cost:</u>	\$ _____	\$ _____
<u>W7334</u> - Description of item/services: _____		
<input type="checkbox"/> Specific one time set-up fees or deposits (utilities, telephone, (utilities, telephone, electric and gas heating)		
<u>Estimated Cost:</u>	\$ _____	\$ _____
<u>W7335</u> - Description of item/services: _____		
<input type="checkbox"/> Personal and environmental health and safety assurances such as pest eradication, allergen controls and one-time cleaning prior to occupancy		
<u>Estimated Cost:</u>	\$ _____	\$ _____
<u>W7336</u> - Description of item/services: _____		
<u>Total Cost:</u> \$ _____ \$ _____		

Other Resources - *Please check all boxes below.* Individuals **must** pursue other third party payer and community programs/resources to pay for modification and technology **before** requesting SNHTF. List name of resource, contact person, phone number and date requested in the text box. If you need more space list details below under additional information. SNHTF is always the payer of last resort.

	<u>DENIED</u>	<u>RECEIVED</u>	<u>PENDING</u>
Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cash Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Maintenance Deduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PA-DCED Accessible Housing Program Grant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Plan – DME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Civic Organizations <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Religious Groups <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
County Funded Resources <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless Assistance Programs <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Volunteer Groups <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Philanthropy <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resources for Food <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other – Not specified above (describe below) Describe: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Types of Services - SNHT Funding Only: SNHTF are State-Only funds and contingent on the availability of those funds. NHT partners should submit requests for SNHTF items/services when individuals are not eligible for the waiver program.

Home adaptations/modifications and specialized equipment (DME) for participants enrolled in waiver programs should be accessed through waiver programs. However, when the amount exceeds the waiver limit, NHT partners should submit requests for SNHT funding for only the amount that exceeds the waiver limit – *if cost cap applies.*

Home adaptations/modification – *Note: If this is a waiver participant, indicate only the amount that exceeds the waiver limit* Estimated Cost: \$
Description of item/services:

Equipment – *Note: If this is a waiver participant, indicate only the amount that exceeds the waiver limit* Estimated Cost: \$
Description of item/services:

Stranded Cost - *Transition expenses paid, but consumer did not transition*
Note: Please explain why the consumer did not transition Estimated Cost: \$
Describe:

Food - **Note: Maximum food allowance \$150/month** Estimated Cost: \$
What food pantry did you attempt to utilize?

Other – *Not specified above. Other items not covered by waiver* Estimated Cost: \$

Total Cost: \$ _____

Nursing Home Transition Purchase Check List

Check Box of items needed and include estimated cost after each item in the text box

KITCHEN

- | | |
|---|---|
| <input type="checkbox"/> Glasses/ Cups \$ _____ | <input type="checkbox"/> Bowls \$ _____ |
| <input type="checkbox"/> Plates \$ _____ | <input type="checkbox"/> Pots/ Pans \$ _____ |
| <input type="checkbox"/> Silverware/ Knives \$ _____ | <input type="checkbox"/> Drying Rack \$ _____ |
| <input type="checkbox"/> Cooking Utensils \$ _____ | <input type="checkbox"/> Dish Towels/ Cloths \$ _____ |
| <input type="checkbox"/> Hot Pads/ Oven Mitts \$ _____ | <input type="checkbox"/> Trashcan \$ _____ |
| <input type="checkbox"/> Microwave/ Toaster Oven \$ _____ | <input type="checkbox"/> Other \$ _____ |

BATHROOM

- | | |
|--|--|
| <input type="checkbox"/> Bath Towels \$ _____ | <input type="checkbox"/> Washcloths \$ _____ |
| <input type="checkbox"/> Toothbrush \$ _____ | <input type="checkbox"/> Shampoo \$ _____ |
| <input type="checkbox"/> Toothpaste \$ _____ | <input type="checkbox"/> Conditioner \$ _____ |
| <input type="checkbox"/> Soap Holder \$ _____ | <input type="checkbox"/> Hand Soap \$ _____ |
| <input type="checkbox"/> Non-Skid Bathtub Mat \$ _____ | <input type="checkbox"/> Shower Curtain Liner \$ _____ |
| <input type="checkbox"/> Shower Curtain Rings \$ _____ | <input type="checkbox"/> Toothbrush Holder \$ _____ |
| <input type="checkbox"/> Toilet Brush \$ _____ | <input type="checkbox"/> Small Trashcan \$ _____ |
| <input type="checkbox"/> Toilet Paper \$ _____ | <input type="checkbox"/> Hamper \$ _____ |
| <input type="checkbox"/> Floor Mat \$ _____ | <input type="checkbox"/> Other \$ _____ |

BEDROOM

- | | |
|--|---|
| <input type="checkbox"/> Sheets \$ _____ | <input type="checkbox"/> Blanket \$ _____ |
| <input type="checkbox"/> Pillow \$ _____ | <input type="checkbox"/> Hangers \$ _____ |
| <input type="checkbox"/> Mattress Cover \$ _____ | <input type="checkbox"/> Other \$ _____ |

DINING/ LIVING ROOM FURNITURE

- | | |
|--|--|
| <input type="checkbox"/> Loveseat or chair \$ _____ | <input type="checkbox"/> 1 Lamp (if no overhead lighting) \$ _____ |
| <input type="checkbox"/> 1 End Table if Necessary \$ _____ | <input type="checkbox"/> Dinette Set \$ _____ |
| <input type="checkbox"/> Other \$ _____ | <input type="checkbox"/> Other \$ _____ |

BEDROOM FURNITURE

- | | |
|---|--|
| <input type="checkbox"/> Bed \$ _____ | <input type="checkbox"/> Nightstand \$ _____ |
| <input type="checkbox"/> Dresser \$ _____ | <input type="checkbox"/> Lamp \$ _____ |
| <input type="checkbox"/> Other \$ _____ | <input type="checkbox"/> Other \$ _____ |

CLEANING SUPPLIES	
<input type="checkbox"/> Vacuum or Broom/ Dust Pan \$ [REDACTED]	<input type="checkbox"/> Trash Bags \$ [REDACTED]
<input type="checkbox"/> All Purpose Clean \$ [REDACTED]	<input type="checkbox"/> Laundry Detergent \$ [REDACTED]
<input type="checkbox"/> Paper Towels/ Tissues \$ [REDACTED]	<input type="checkbox"/> Mop \$ [REDACTED]
<input type="checkbox"/> Bucket \$ [REDACTED]	<input type="checkbox"/> Other \$ [REDACTED]
MISCELLANEOUS	
<input type="checkbox"/> Phone or Phone Card \$ [REDACTED]	<input type="checkbox"/> Other \$ [REDACTED]

Additional Information - Not Specified Previously:

Please provide any facts that may not be included on this form, but are relevant to the consumer's specific situation.

Describe: [REDACTED]

For State Use Only – Do Not Complete This Section

Request for Services through Waiver CTS – Bill to Waiver (CTS)

Date: Item/Services Requested:

Approved: Total Amount Approved: \$

Denied: Reason for Denial:

Follow-up on Outstanding Issues:

***** IMPORTANT INFORMATION *****

Please note that these costs must be included in your initial service plan in **HCIS or SAMS** care plan, which is to be submitted prior to discharge to the community.

Use the appropriate billing code for the specific CTS category listed in the **Request for Community Transition Services (CTS) funding section** when billing for these approved services.

Request for Services through SNHTF - Bill to SNHTF (CTS)

Date: Item/Services Requested:

Approved: Total Amount Approved: \$

Denied: Reason for Denial:

Follow-up on Outstanding Issues:

***** IMPORTANT INFORMATION *****

Please note that these costs must be included in your initial service plan in **SAMS** care plan, which is to be submitted prior to discharge to the community.