NHT Outreach Form

1. APPROPRIATE COMPLETION OF FORM IS REQUIRED FOR PAYMENT

1.A. Participant Identification

1. DATE Transition Case Opened

2. FIRST Name

3. Middle INITIAL

4. LAST Name

5. Name SUFFIX (if applicable)

6. Social Security Number (SSN)

7. DATE of CURRENT Medicaid Enrollment (if applicable)

8. MEDICAID Number (if applicable)

9. DATE of Birth (DOB)

1.B. Participant Demographics

1. GENDER

- ☐ Female
- ☐ Male

2. Current MARITAL Status

- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Other-Document in Notes
- ☐ Unavailable

3. Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

4. Race(s)

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

2. NHT INFORMATION

2.A. GENERAL Information

1. Reason for Completing the Outreach Form?

- ☐ NHT Transition - Non-NFP
- ☐ NHT Transition - MFP
- ☐ LIFE
- ☐ Diversion

2. Date Participant was admitted to the Nursing Facility

3. Does the Participant have a scheduled discharge date?

- ☐ No
- ☐ Yes

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

5. Enter any intake/referral comments

6. Identify source of the Participant's referral for transition. If source is not listed, document Details in Notes.

- ☐ AAA
- ☐ Center for Independent Living
- ☐ Family
- ☐ Friend
- ☐ Home Health Agency
- ☐ Hospital
- ☐ Nursing Home/Rehab Facility (non Section Q related)
- ☐ FDIS
- ☐ Section Q Referral
- ☐ OBRA-Target/Specialized Services
- ☐ OLTL Community Partner
- ☐ Ombudsman
- ☐ PA Link
- ☐ Physician
- ☐ Self
- ☐ Social Services Agency
- ☐ Other-Document Details in Notes

7. Does Participant have a Legal Guardian?

- ☐ Yes-Document Name in Notes
- ☐ Yes, Court Appointed, Document name in Notes
- ☐ No

8. If Participant met the eligibility requirements, did the Participant sign the MFP Informed Consent Form agreeing to participate in the Money Follows the Person (MFP) Demonstration Program? If Yes, Section 5 must be completed.

- ☐ No-Document any reasons stated in Notes
- ☐ Yes
- ☐ Participant was not offered the form-Document Details in Notes.

2.B. ADDRESS of NURSING FACILITY

1. Nursing Facility COUNTY

2. Nursing Facility's MA Provider Number

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

4. Nursing Facility Address

5. Nursing Facility Town/City

6. Nursing Facility Zip Code

7. Nursing Facility Telephone Number

8. MPI Number (Master Provider Index)

3. TRANSITION Information

3.A. TRANSITION DATA - Complete 3.A.5 only if the response to 3.A.4 is NO

1. Date Nursing Home Transition (NHT) Outreach Form was completed?

2. Name of individual completing the NHT Outreach Form?

3. Was the Participant informed about the MFP program?

- ☐ No
- ☐ Yes

4. Did the Participant complete transition to the community? If MFP, must complete Section 5.

- ☐ NO - Document in 3.A.5 the reasons Participant did NOT transition
- ☐ YES - SKIP to 3.A.6 - DO NOT enter a response in 3.A.5.

5. List the BARRIERS that PREVENTED the Participant from transitioning and document details in Notes. Additional Barriers SPECIFIC TO MFP Participants are to be entered in 5.A.2.
DO NOT ENTER a response here if answer to 3.A.4 was YES.

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

6. If Participant transitioned, enter date of transition.

7. Name of the person responsible for Participant's transition plan.

8. Telephone number of the person responsible for Participant's transition plan.

9. Name of the Agency/Provider responsible for Participant's transition plan.

10. NHT Provider's Medicaid #

11. PSA ID Number if Appropriate

- [ ] 01
- [ ] 02
- [ ] 03
- [ ] 04
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- [ ] 49
- [ ] 50
- [ ] 51
- [ ] 52

12. Indicate the Waiver or HCBS Program to which the Participant transitioned.

- [ ] Act 150 Attendant Care
- [ ] Consolidated Waiver
- [ ] COMMCARE Waiver
- [ ] FCSP-Family Caregiver Support Program
- [ ] LIFE-Living Independence for the Elderly
- [ ] OBRA Waiver
- [ ] Attendant Care Waiver
- [ ] OPTIONS
- [ ] Independence Waiver
- [ ] Aging Waiver
- [ ] Not MA Eligible
- [ ] Not Waiver Eligible
- [ ] No HCBS Sought
- [ ] Other - Document in Notes

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

- [ ] Family Issues
- [ ] Home Modifications
- [ ] Housing
- [ ] Lack of Formal/Informal Support
- [ ] Lack of Funding
- [ ] Service Provider Availability
- [ ] Unaware of Services/Lack of Information
- [ ] Other-Document Details in Notes
- [ ] Accessing Employment
- [ ] Accessing Mental Health Services
- [ ] Accessing Public Assistance (i.e. LIHEAP, SNAP)
- [ ] Accessing Special Nursing Home Transition Funds (SNHTF)
- [ ] Accessing Substance Abuse Services
- [ ] Accessing Waiver Services

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

1. RESIDENTIAL County – REQUIRED

- [ ] Adams
- [ ] Allegheny
- [ ] Armstrong
- [ ] Beaver
- [ ] Bedford
- [ ] Berks
- [ ] Blair
- [ ] Bradford
- [ ] Bucks
- [ ] Butler
- [ ] Cambria
- [ ] Cameron
- [ ] Carbon
- [ ] Centre
- [ ] Chester
- [ ] Clarion
- [ ] Clearfield
- [ ] Clinton
- [ ] Columbia
- [ ] Crawford
- [ ] Cumberland
- [ ] Dauphin
- [ ] Delaware
- [ ] Elk
- [ ] Erie
- [ ] Fayette
- [ ] Forest
- [ ] Franklin
- [ ] Fulton
- [ ] Greene
- [ ] Huntingdon
- [ ] Indiana
- [ ] Jefferson
- [ ] Juniata
- [ ] Lackawanna
- [ ] Lancaster
- [ ] Lawrence
- [ ] Lebanon
- [ ] Lehigh
- [ ] Luzerne
- [ ] Lycoming
- [ ] McKean
- [ ] Mercer
- [ ] Mifflin
- [ ] Monroe
- [ ] Montgomery
- [ ] Montour
- [ ] Northampton
- [ ] Northumberland
- [ ] Perry
- [ ] Philadelphia
- [ ] Pike
- [ ] Potter
- [ ] Schuylkill
- [ ] Snyder
- [ ] Somerset
- [ ] Sullivan
- [ ] Susquehanna
- [ ] Tioga
- [ ] Union
- [ ] Venango
- [ ] Warren
- [ ] Washington
- [ ] Wayne
- [ ] Westmoreland
- [ ] Wyoming
- [ ] York
- [ ] Out Of State

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

3. RESIDENTIAL Street Address Second Line (if needed)

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

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

6. RESIDENTIAL State

7. RESIDENTIAL Zip Code (Optional)

8. TELEPHONE Number

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

- [ ] Participant will submit completed Voter Registration Form
- [ ] AAA will submit completed Voter Registration Form
- [ ] Participant declined-already registered to vote
- [ ] Participant declined Voter Registration Form
- [ ] Not Applicable

4. CLOSEOUT Information

4.A. HOUSING

1. Did the Participant transition to existing housing?

- [ ] No
- [ ] Yes-Skip to 4.A.5

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

- [ ] No
- [ ] Yes

3. How was housing located?

- [ ] Family
- [ ] Friend
- [ ] Housing Authority
- [ ] Local Lead Agency
- [ ] Newspaper
- [ ] PA Housing Search
- [ ] Regional Housing Coordinator Assistance (RHC)
- [ ] Other-Document Details in Notes

4. Date housing was secured

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

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

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

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

7. List all Barriers the participant encountered in obtaining affordable accessible housing in the community:

- [ ] Criminal Background
- [ ] Housing Waiting List
- [ ] Lack of Accessible Housing
- [ ] Lack of Affordable Housing
- [ ] Lack of Subsidized Housing Vouchers
- [ ] Lack of Transportation Where Housing is Available
- [ ] Physical Location of Available Housing
- [ ] Poor Credit
- [ ] Other

4.B. Home Modifications/Adaptations/Assistive Technology

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

- [ ] No
- [ ] Yes

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

- [ ] Doorways widened
- [ ] Kitchen/bathroom modifications
- [ ] Ramp
- [ ] Stair Glide
- [ ] Walk-in Shower
- [ ] Other

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

5.A. MFP Required Data

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

- [ ] No-Document Details in Notes- Complete question 5.A.2
- [ ] Yes - Skip to Question 5.A.3

2. Select all barriers specific to the MFP Program that prevented the Candidate from enrolling in the MFP Program. These barriers are in addition to any barriers listed in 3.A.5.

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

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

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

4. Does Participant live with family members?

- [ ] No
- [ ] Yes

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

- [ ] Yes
- [ ] No

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

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