

Relocation Services for Nursing Home Residents

Doni Green
Area Agency on Aging of North Central Texas

MDS 3.0 Section Q

Facilities must make facilitated referrals on behalf of residents who want to return to the community and don't have active discharge plans

Q0300: Resident's Overall Expectation

Resident's overall goal established during the assessment process

1. *Expects to be discharged to the community*
2. Expects to remain in this facility
3. Expects to be discharged to another facility/institution

Q0400: Discharge Plan

Is there an active discharge plan in place for the resident to return to the community?

0. *No*

1. Yes—skip to Q0600

Q0500: Return to Community

“Do you want to talk to someone
about the possibility of
returning to the community?”

0. No

1. *Yes*

Q0600: Referral

Has a referral been made to the local contact agency?

0. No—determination made by resident and the care planning team that contact is not required

1. No—referral not made

2. *Yes*

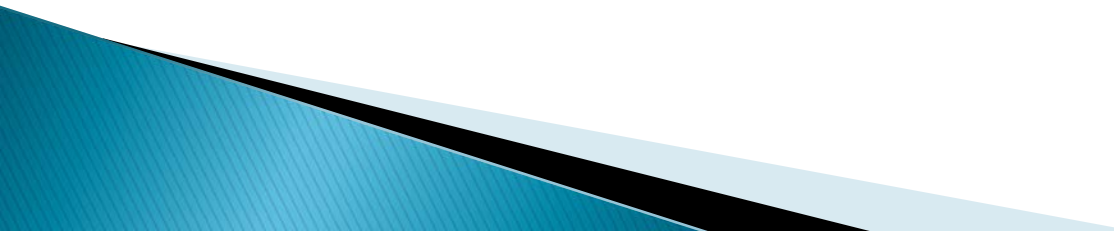


Facilities' Responsibilities

Notify Local Contact Agency if residents express a desire to learn about possible transition back to the community, care options, and supports

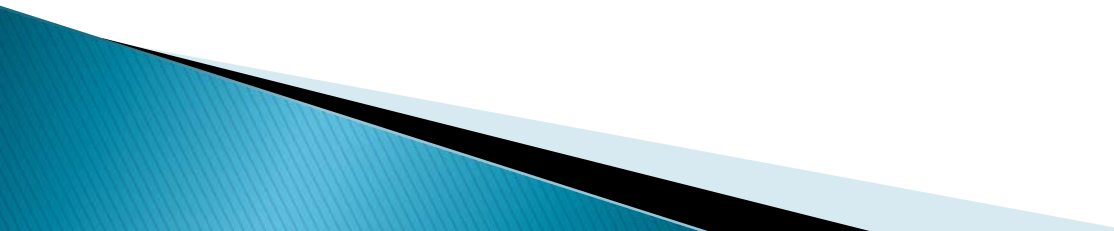
Local Contact Agencies' Responsibilities

Timely respond to nursing home staff referrals by providing information to residents about available community-based long-term care supports and services

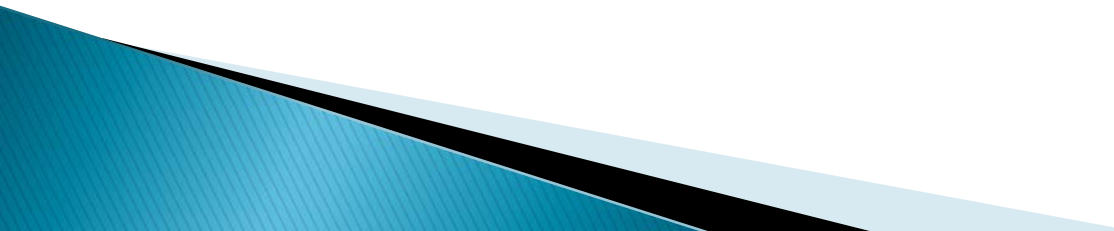


Both Parties' Responsibilities

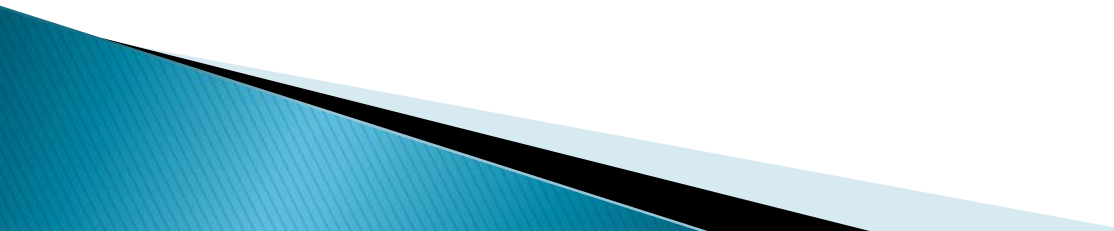
Engage the resident in discharge and transition plan and collaboratively work to arrange for all of the necessary community-based long-term care services



Options Counseling

- Serves non-Medicaid residents
 - Both phone and face-to-face consultation available
 - Call 1-877-229-9084
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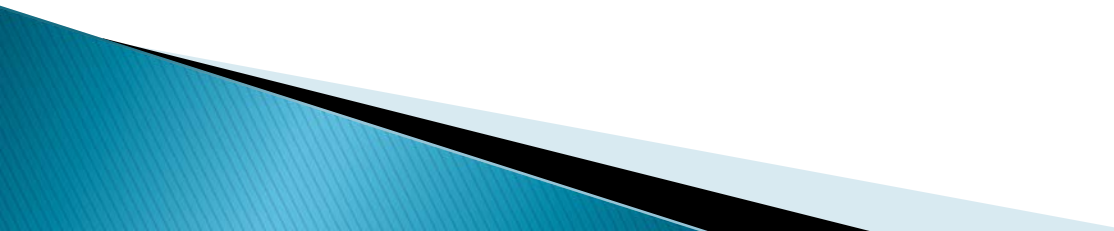
Intense Case Management/ “Home by Choice”

- Must be Medicaid–eligible (i.e., have community and/or nursing home Medicaid)
 - Services provided on–site at nursing home
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Home by Choice

Target Population

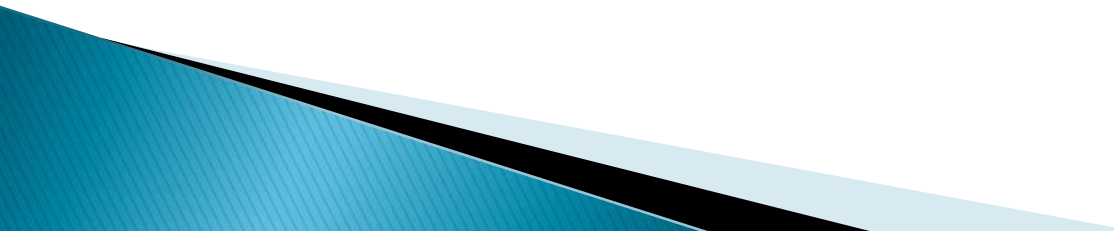
Persons with complex needs, as defined by the State (e.g., lack of housing, residence in facility of three months or longer, impairments of five or more activities of daily living, co-occurring physical and mental disabilities)



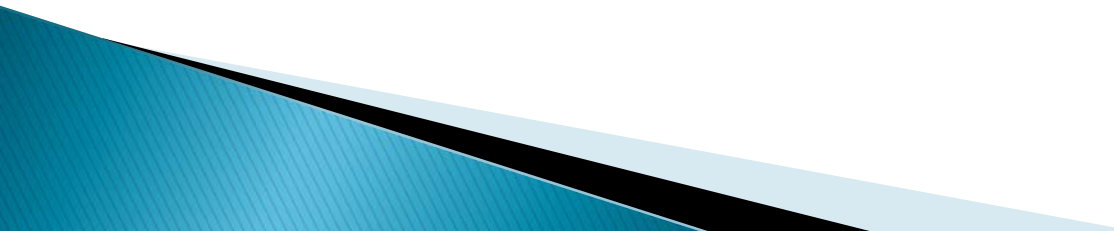
Scope of Home by Choice

Coordinate State and local programs (especially non-Waiver programs), help find suitable housing, apply for public benefits, arrange for public transportation, follow up post-transition

Medicaid Waiver Programs (1)

- STAR+PLUS: bypass
 - Community Living Assistance and Support Services: bypass
 - Medically Dependent Children's Program (bypass)
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Medicaid Waiver Programs (2)

- Deaf Blind Multiple Disabilities (no bypass)
 - Home and Community Services (bypass for children only)
 - Texas Home Living (no bypass)
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Home by Choice Processes (1)

- Within two weeks of referral, relocation specialist (RS) will assess resident in facility and develop independent living plan
- RS will coordinate with waiver case manager and all others resident wishes to have involved

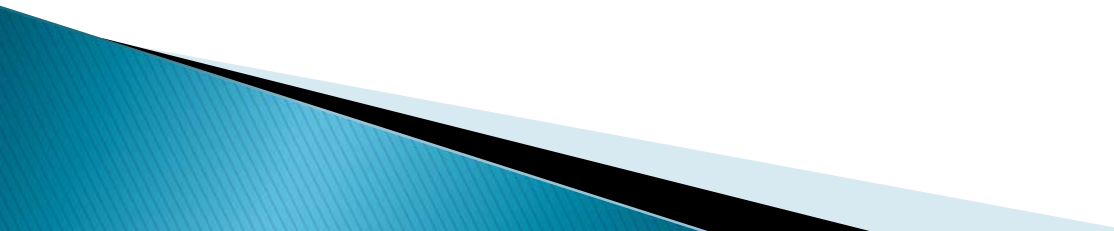
Home by Choice Processes (2)

- RS will make at least monthly contact
 - RS will remain involved until resident relocates, withdraws from program, or loses eligibility
 - RS will follow those who relocate for at least 90 days post-relocation
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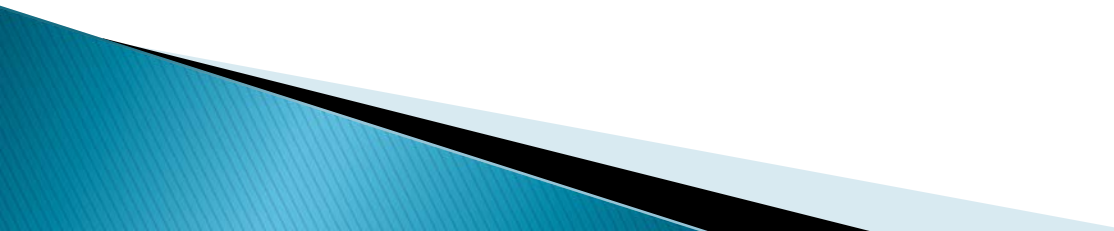
Relocation Grants

- Transition Assistance Services (TAS): one-time grant, not to exceed \$2,500 for deposits, essential furnishings, etc.; arranged by HMOs
- Transition to Life in the Community (TLC): one-time grant, not to exceed \$2,500 for food, clothing, etc.; arranged by relocation specialists
- Grants available to Medicaid beneficiaries only

Home by Choice Timelines

- In general, at least two months to arrange waiver services
 - May take up to several months to secure subsidized, independent housing
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Home by Choice Application Procedures

- Call 1-800-272-3921, ext. 7193 or 7398, or
 - Fax face sheet to metro (817) 695-9274
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More Information

- Call (817) 695-9193 or (817) 608-2398
- Email: dgreen@nctcog.org or tbusby@nctcog.org