Long Term Care Waiver Operations

2014 Provider Training

Living Choice-MFP

Medically Fragile

My Life; My Choice

Sooner Seniors

OVERVIEW OF PRESENTATION

- Website
- Living Choice
- My Life; My Choice
- Sooner Seniors
- Medically Fragile
- Withdrawal/Discharge (Post-Transition)
- Critical Incidents Evaluation/Investigation
- Addendums
- Self-Direction

Website

www.okhca.org → individuals→ Long-Term Care Services

Living Choice Referral

Referral can be made through Long Term Care Waiver Ops Website at www.okhca.org → individuals→ Long-Term Care Services and/or faxed to 405-530-7265.

Once referrals are screened by LTCWO staff, they are then sent to OU Pre-Assessment Team (PAT).

- APS Check
- Court Ordered
  Legal Guardian/MED POA

OU Pre-Assessment Team

LONG TERM CARE WAIVER OPERATIONS
COMMON INTAKE FORM

Fax form to Long Term Care Waiver Operations: (405) 530-7265

Please Select a Program

☐ Living Choice Demonstration Program

☐ Medically Fragile Waiver Program

Personal Information

Last Name	First Name M.I.	Phone #

SoonerCare ID	Date of Birth	Age	Sex

Do you have a Legal Guardian? ☐ Yes ☐ No	If so, Who? Name:	Phone #
Do you have a Medical Decision Making Power Of Attorney? ☐ Yes ☐ No	If so, Who? Name:	Phone #

Institution Information

Name of Institution where you now live	Room #	Provider ID #

Institution physical address	City	State	Zip	County

Institution director's name	Office Phone

Personal physician's name	Admit Date	Length of stay in current facility:

Person Making Referral:

☐ Self ☐ Family Member ☐ Nursing Facility ☐ Other

Name:	Agency/Relationship:	Phone #:

How did you hear about the Living Choice Project?

☐ Self ☐ Family Member ☐ Nursing Facility ☐ MDS 3.0 ☐ Other:

FOR OFFICIAL USE ONLY

Date Received:	Date forwarded to OU PAT:	Eligibility Determination Date:	Assigned to:

OU Pre-Assessment Team

- Pre-Screening Form
- Introduction to Living Choice Program
- QOL
- Consents & Rights
- Release of Information
- UCAT I & III
- Participant Transition Planning Guide (will be left w/ Participant)

OU Pre-Assessment Team will provide a list of available TC/CM's in the participant's county.

Oklahoma Health Care Authority

MFP MONEY FOLLOWS THE PERSON

Transition Pre-Screening Form

Oklahoma's Living Choice – MFP

Participant Name: _____ Medicaid ID #: _____

Screening Type: (Check box that applies) ☐ Initial Face to Face Screening: (mm/dd/yyyy) _____ ☐ Re-Screen: (mm/dd/yyyy) _____	Pre-Assessment Nurse: _____ Pre-Assessment Nurse Contact: _____	OHCA Nurse: _____ OHCA Nurse Contact: _____
Gender: ☐ Male ☐ Female Date of Birth: (mm/dd/yyyy) _____	Ethnicity: ☐ African American ☐ Asian or Pacific Islander ☐ Hispanic or Latino ☐ Native American ☐ White ☐ Other: (Specify) _____	Population: (Check all boxes that apply) ☐ Older Adult (65+) ☐ Physical Disability ☐ Aged & Disabled ☐ Developmentally Disabled ☐ Other: (Specify)_____

Pre-Assessment Nurse Note: Establish rapport before beginning screening process. Ask the person who they would like to include in the screening process – family members friends, etc. If the person has a guardian, stop the interview and reschedule the screening when the guardian can participate

Hello, my name is _____ and I am with the OU College of Nursing.

I came to visit you about the referral made by you or on your behalf to the Oklahoma Health Care Authority Living Choice Program. Today I will ask some questions and give you some information to get your application for the program started. To get your application started, I am going to ask about your experience here at this Nursing Facility, and then I will give you some information about the Living Choice Program.

So now, let's start with the questions, the Form I will be writing on for these sets of questions is called the Quality of Life survey. This survey will give OHCA an idea of what you think of your experience here in the facility and if you qualify for the program, it will give us something to compare with later on how you feel about living in the community.

Now I would like to tell you about the LC program. The Oklahoma Living Choice Project promotes community living for people of all ages who have disabilities or long-term illnesses. The project gives Oklahomans more options for managing their health care needs and adding more balance to the state's long-term care system.

MONEY FOLLOWS THE PERSON QUALITY OF LIFE SURVEY

The Money Follows the Person Quality of Life Survey (QoL) was designed to measure quality of life in seven domains: living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status. The target population for the survey includes people with disabilities and long-term illnesses who are transitioning from institutionalized care to a care setting in the community. The survey is to be administered to all participants at three points in time—just prior to transition, about 11 months after transition, and about 24 months after transition.

The QoL takes approximately 15 to 20 minutes to complete. A few questions are asked only before or after the transition, although most are asked at all three interviews. The survey is intended to be administered by an interviewer, in person, and in a private setting (e.g., an office in a nursing facility). Depending on the individual circumstances and the abilities of the participant, however, a proxy respondent or an assisted interview may be necessary. A proxy respondent is a person who answers the survey questions on the participant's behalf. In an assisted interview, a third person is present to help the participant answer questions. This survey also has been translated into Spanish.

The development of the QoL survey was funded by the Centers for Medicare and Medicaid Services (CMS) under contract HHSM-500-2005-00025I (0002). The majority of questions are based on the Participant Experience Survey (Version 1.0 of Mental Retardation/Developmental Disabilities 2003, MEDSTAT Group, Inc.), although a few items are drawn from other instruments (ASK ME!, Cash and Counseling, National Core Indicator Survey (NCI), Quality of Life Enjoyment and Satisfaction Questionnaire—Short Form, and the Nursing Home Consumer Assessment of Health Plans Survey (NH CAHPS)).

The survey is free and available for use by the public; no one can use the survey for monetary purposes. Users are expected to include the following citation:

Sloan, Matt, and Carol Irvin. Money Follows the Person Quality of Life Survey. Prepared for Centers for Medicare and Medicaid Services (CMS). Washington, D.C.: Mathematica Policy Research, Inc., 2007.

LONG TERM CARE WAIVER OPERATIONS

☐ **Living Choice** ☐ **My Life; My Choice** ☐ **Sooner Seniors** ☐ **Medically Fragile**

PARTICIPANT CONSENTS & RIGHTS

Participant Name				**SoonerCare ID**	
	Last	*First*	*MI*		

A. SERVICE SETTING

☐ I have decided to pursue participation in the Living Choice Project or Waiver Program to receive services in my own home. I understand that I may change my mind at any time during the process and decide not to continue with this service. (Proceed to Section B)

☐ I have decided **NOT** to pursue participation in the Living Choice Project or Waiver Program and to continue to receive services in the nursing facility. I understand that I may reapply at any time. (Proceed to Section D)

B. INFORMED CHOICE

The verbal selection of TC/CM agency has been obtained from the Participant. Please confirm or revise the following selections during Participant visit.

☐ I choose _____ as my TC/CM agency.
☐ I have no preference. Please select a provider for me.

☐ I choose to keep the previously chosen/assigned selection of TC/CM agency.
☐ I choose to select another TC/CM agency.

☐ I choose _____ (first choice) or _____ (second choice) as my in-home provider agency.
☐ I have no preference. Please select an in-home provider agency for me.

C. LEGAL GUARDIAN OR MEDICAL POWER OF ATTORNEY

I have a: ☐ Legal Guardian ☐ Medical Power of Attorney ☐ Neither (Proceed to Section D)

Name of Guardian/MPOA		
	Last	*First*

Address		Phone	
	Street *City* *Zip*		

D. RIGHT TO A FAIR HEARING

I have been informed of my right to a fair hearing. I understand that I have the right to appeal any action of the Oklahoma Health Care Authority that I consider improper by sending my complaint, in writing, to:

Oklahoma Health Care Authority
4345 N. Lincoln Blvd. Oklahoma
City, OK 73105

E. SIGNATURES

Signature of Participant or Legal Agent Date *(If Participant signs with a mark, two witnesses are required.)*	Signature of TC/CM Date
Signature of Witness Date	Signature of Witness Date

Long Term Care Waiver Operations

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

RELEASE OF INFORMATION

Participant Name				SoonerCare ID	
	Last	*First*	*MI*		

A. ACKNOWLEDGEMENT

I authorize the Long Term Care Waiver Operations of the Oklahoma Health Care Authority to share with the providers named below my medical or social information necessary to arrange and evaluate services that will enable me to regain or maintain my personal independence.

I authorize the release of all my Medical records to the Long Term Care Waiver Operations to arrange and evaluate services that will enable me to regain or maintain my personal independence.

Pursuant to Oklahoma Statute, Title 63, Section 1-502(B), I have been advised that the information I authorize for release may include information that could be considered information about non-communicable or communicable diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I understand my information will not be released in any way that would identify me to other agencies or agents without my prior written consent.

This authorization is in effect for one (1) year from the original date of my signature. I understand that I may revoke this authorization at any time.

B. SERVICE TEAM MEMBERS

Oklahoma Health Care Authority (LTCWO)

OU College of Nursing Case Management

Signature of Participant or Legal Agent **Date** *(If Participant signs with a mark, two witnesses are required.)*	**Signature of TC/CM** **Date**
Signature of Witness **Date**	**Signature of Witness** **Date**

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Uniform Comprehensive Assessment, Part I
Intake and Referral

Numbers in parenthesis refer to item numbers in the Oklahoma Long-Term Care Authority (OLTCA) Manual.

Applicant information.

(1) **Indicate use of form**	(2) **Date completed (mo/day/year)**	(3) **Source of referral to this office List name, source, telephone - or - readmit**
Intake		
Screen and prioritization		
Comprehensive assessment		
Reassessment		
Referral out of this office		

Consumer information.

(4) Last name	First	MI	(8) Date of birth	
(5) Social Security number	Case number	Unique ID number	Area code	(9) Phone
(6) Street address	(7) City	State	Zip	

Additional sources of information.

(10) Last name	First	MI	Area code	(11) Phone
(12) Street address	City	State	Zip	

(13) Relation to consumer:

☐ Family, specify _____ ☐ Friend ☐ Hospital ☐ Other, specify _____

(14) Does the consumer know about this call or assessment interview? ☐ Yes ☐ No

(15) **(Ask)** What problems do you have right now that are causing you difficulty or what do you need assistance with? How long have you had these needs? What services are you receiving?

02HM003E-001

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Uniform Comprehensive Assessment, Part III

Medical (Level of Care) Assessment

Assessment information.

(Assessor) Attach completed Form 02HM001E, Uniform Comprehensive Assessment, Part I, Intake and Referral. Numbers in parenthesis refer to item numbers in the Oklahoma Long-Term Care Authority (OLTCA) Manual.

(1) Consumer name		Date
Social Security number (2)	Case number	Unique ID number

(3) Location of: ☐ assessment ☐ reassessment
☐ consumer's residence ☐ relative's home ☐ nursing home
☐ hospital ☐ other, specify _____

Mental status questionnaire (MSQ)

(Assessor) Write responses to questions. Do not score until section is completed. Count one error for each incorrect response up to the maximum errors for the item. No response is counted as an incorrect response.

(4) **(Say)** I'm going to read you a list of questions. These are questions often asked in interviews like this and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with the current year.

Question	Answer	Maximum errors	Score	Weight	Weighted score
What year is it now?	_____	1	_____	X 4 =	_____
What month is it now?	_____	1	_____	X 3 =	_____

(Say) I'm going to give you a man's name and address to memorize and you will be asked to repeat the phrase later.

Memory phrase: **John Brown, 42 Market Street, Chicago**

Elicit three correct repetitions from the consumer, phrase by phrase or word by word, if necessary, before continuing.

(Ask) Without looking at a clock, what time is it? (within one hour)

Time is: _____ Response: _____ 1 _____ X 3 = _____

Oklahoma Health Care Authority (OKHCA)
Living Choice Project

Authorization to Release Information

I, _____, authorize Oklahoma Housing Finance Agency (OHFA) to discuss and release information about my application, (re)certification, inspection, etc. for the Section 8 Housing Choice Voucher Program to the Oklahoma Health Care Authority (OKHCA) Living Choice Transition Coordinator or Quality Assurance & Review Officer listed below.

_____	_____
Print Name of Transition Coordinator	Print Name of Agency Represented
David Ward	Long-Term Care Waiver Operations
Quality Assurance & Review	OKHCA

I understand this authorization shall remain in effect until I submit a signed letter to OHFA requesting to terminate the authorization.

_____	_____
Signature of Applicant/Participant	Date

Oklahoma Health Care Authority (OKHCA)
Living Choice Project

Referral for Services
to
Oklahoma Housing Finance Agency (OHFA)

_____	_____	_____
Print Name of Applicant	**SSN (last four digits only)**	**Referral Date**

_____	_____
Print Name of Transition Coordinator	**Print Name of Agency Represented**

_____
Transition Coord. Phone Number (incl. area code)

MONEY FOLLOWS THE PERSON

Money Follows the Person

Participant Transition Planning Guide

for returning to the community

2014

MFP Participant Name: _____

Anticipated Discharge Date: _____

oklahoma health care authority

Oklahoma
Health
Care
Authority

Long Term Care Waiver Operations Divison

TC/CM

Once the participant has been deemed program appropriate, the TC/CM will receive the *Pre-Screening Form*, *UCAT I & III*, and any recommendations made by OHCA for successful transition.

TC/CM will use the *Participant Transition Planning Guide* as a resource to assist the participant in successfully transitioning back into the community.

1) TC/CM will assist the participant in acquiring proper identification to secure affordable housing.
2) Once identification and housing are obtained, TC/CM will begin developing the *Community Service Plan* and *Community Back-Up Plan* to ensure the participant's needs in the community are met.
3) Once the *Community Service Plan* and *Community Back-Up Plan* are approved, TC/CM may begin purchasing essential household items.

****Case Notes/Progress Notes**** are due on the 5th of every month. The monthly Case Notes will give us a greater understanding of where the member is in the pre-transition process. **This only applies to Living Choice Participants.**

i.e. The report for January (which covers January 1st-31st) is due Feb 5th.

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

CASE MANAGEMENT NOTES

Participant Name				SoonerCare ID	
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES

TC/CM Name

TC/CM Signature

Units (this page)
Total Units

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

CASE MANAGEMENT NOTES

Participant Name				SoonerCare ID	
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES

TC/CM Name

TC/CM Signature

Units (this page)
Total Units

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

CASE MANAGEMENT NOTES

Participant Name				SoonerCare ID	
	Last	*First*	*M.I.*		

DATE	START	STOP	TIME	UNITS	NOTES

TC/CM Name

TC/CM Signature

Units (this page)
Total Units

Services offered under Living Choice

- Adult day health care
- Advanced supportive/restorative assistance
- Assisted Living
- Assistive technology
- Audiology treatment and evaluation
- Community Transition (up to $2,400)
- Dental services (up to $1000 per person per annually)
- Environmental modification
- Family counseling
- Family training
- Home delivered meals
- Hospice care
- Independent living skills training
- Institutional Transition Services
- Nutritional educational services
- Prescription drugs
- Personal care
- Personal emergency response system(PERS)
- Psychiatry
- Psychological services
- Respite
- Self-Direction
- Self Directed Goods and Services (SD-GS)
- Skilled Nursing
- Private duty nursing
- Specialized medical equipment
- Therapy services: Occupational
- Therapy services: Physical
- Therapy services: Speech
- Transition coordination
- Transportation
- Vision services to include eye exams and glasses.

30/60/90 Day Cycle

Living Choice

60 Days

*Identification

*Housing Resources

90 Days

*Secure Housing

*Community Service Plan

*Community Back-Up Plan

120 Days

*Purchase items needed for participant

*Set Transition Date

150 Days

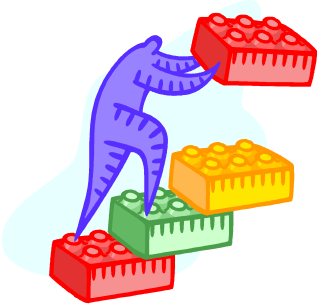
*IDT

*Provider Communication

*Addendum-Transitional Units

*5 Day Follow-Up

* The first 30 days are the Pre-assessment activity period



LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

COMMUNITY SERVICE PLAN AUTHORIZATION REQUEST CHECKLIST

Participant Name				SoonerCare ID	
	Last	*First*	*Middle*		

☐ A. INITIAL ASSESSMENT

Pre-assessment

_____ Participant Consents and Rights
_____ Release of Information
_____ UCAT I & III
_____ Quality of Life Survey (QOL)

Post-assessment

_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan

STOP
This Section only pertains to The Living Choice Demonstration Program

☐ B. INITIAL COMMUNITY SERVICE PLAN

_____ Participant Consents & Rights
_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan
_____ UCAT (Parts I & III)
_____ Other, only if necessary for this plan (i.e. Nutritional Supplement, Environmental Mods)

☐ C. REASSESSMENT

_____ Participant Consents & Rights
_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan
_____ UCAT (Parts I & III)
_____ Other, only if necessary for this plan (i.e. Nutritional Supplement, Environmental Mods)

☐ D. ADDENDUM

_____ Community Service Plan Addendum
_____ Revised Goal(s)
_____ Other, only if necessary for this plan

SIGNATURES

Documentation marked above was sent:

TC/CM Agency	TC/CM Signature	Date

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

COMMUNITY SERVICE PLAN

☐New ☐Reassessment

Participant Name				SoonerCare ID	
	Last	*First*	*M.I.*		

A. HOUSING INFORMATION (LIVING CHOICE PARTICIPANTS ONLY)

Housing Supplements (Check all that apply):

☐ Low-Income Housing Tax Credits
☐ HOME Dollars
☐ CDBG Funds
☐ Housing Choice Vouchers
☐ Housing Trust Funds
☐ Section 811
☐ 202 Funds
☐ USDA Rural Housing Funds
☐ Veteran's Affairs Housing Funds
☐ Funds for Home Modifications
☐ Funds for Assistive Technology related to Housing
☐ Other _____
☐ Not Applicable

Living Arrangements:

Will Participant live with family?
☐ Yes
☐ No

Housing Type:

☐ Home – owned by Participant
☐ Home – owned by family member
☐ Apartment – not assisted living
☐ Apartment – assisted living
☐ Group home of no more than 4 people

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

COMMUNITY SERVICE BACK-UP PLAN

Participant Name				SoonerCare ID #	
	Last	*First*	*M.I.*		

REQUIRED DOMAINS				
NOTE: Disaster-preparedness is not addressed in this document – See Disaster Preparedness Plan for actions related to disaster planning.				
List Specific Risks	**Tier I** Formal Support	**Tier II** Informal Support	**Tier III** Back-Up Support	**Tier IV** Extreme Emergency
Direct Care Assistance			Oklahoma 2-1-1 for 24-hour backup support	☐ 911 ☐ Other
Critical Health - Supportive Services			Oklahoma 2-1-1 for 24-hour backup support	☐ 911 ☐ Other

Participant/Legal Representative Initials_____

NOTE: Full signature required on final page only. Initials required for all other pages.

OKHCA Revised 1-1-2014

Day of Transition

- IDT-(Member & TC/CM)
- Provider Communication (notify OHCA of move)
- Addendum-Transitional Units (30 days from Transition Date)
- Transitional Funds (receipts due 30 days of purchase)
- 5 Day Follow-Up
- Housing (TC/CM should be listed as Emergency Contact)

LONG TERM CARE WAIVER OPERATIONS

☐ **Living Choice** ☐ **My Life; My Choice** ☐ **Sooner Seniors** ☐ **Medically Fragile**

IDT MEETING

Participant Name				**SoonerCare ID**	
	Last	*First*	*M.I.*		

Start	Stop	Time	Units

Signature	**Title**	**Relationship/Agency**

Agenda Goals:

1. Educated Participant to the philosophy, purpose and service the program provides. ☐ Yes ☐ No
2. TC/CM determined if other payment sources were available to purchase needed services prior to using Medicaid funding. ☐ Yes ☐ No

IDT Progress Notes:

_____

_____

_____

_____

The Participant has received the following information:

☐ Participant Assurances, Rights and Responsibilities
☐ Reporting Suspected Abuse, Neglect and Exploitation
☐ SoonerRide Brochure
☐ OKHCA Complaint/Grievance Form
☐ Request for a Fair Hearing Form
☐ Other _____ (i.e. agency brochure and agency orientation)

I,_____, have been given the above information. I have had the information explained to me and have been given the opportunity to ask questions so that I fully understand the information.

_____ _____
Member's Signature Date

_____ _____
TC/CM Signature Date

_____ _____
TC/CM Name (please print) TC/CM Agency

Total Units: _____

Long Term Care Waiver Operations

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

PROVIDER COMMUNICATION

Participant Name				
	Last	*First*	*M.I.*	*SoonerCare ID*

A. EVENT CHANGE

_____ Hospital Admission DATE

_____ Vacation Begin DATE

_____ Temp Nursing Facility Placement DATE

_____ Other Begin DATE (Please Specify) _____

_____ Suspension BEGIN DATE

_____ Hospital Discharge DATE

_____ Vacation End DATE

_____ Discharge DATE

_____ Other End DATE

_____ Suspension END DATE

B. ADDRESS CHANGE

Current Address				
	Street	***City***	***State***	***Zip***
New Address				
	Street	***City***	***State***	***Zip***

_____New Address effective DATE

_____Updated Phone Number (if necessary)

Type of qualified residence (Select one of the following):

- ☐ Home owned by participant
- ☐ Home owned by family member
- ☐ Apartment leased by participant, not assisted living
- ☐ Apartment leased by participant, assisted living
- ☐ Group home of no more than 4 people

Participant lives with family members:

- ☐ Yes
- ☐ No

C. TC/CM CHANGE

Current TC/CM			
New TC/CM		**Effective Date**	
Submitted by	**Agency**		**Date**

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

COMMUNITY SERVICE PLAN ADDENDUM

Participant Name				SoonerCare ID	
	Last	*First*	*M.I.*		

REVISED SERVICES AND GOALS

Put Appropriate Amount for the Pay/Support Source: I=Informal; P=Private Pay; O=Other; M=Medicare; SP=State Plan; SC=Self Care

SERVICE/SUPPORT

Service line to be ended:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

Service line to be added:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

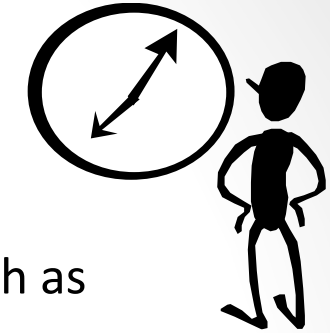
GOALS

Expected Outcome	Action Steps	Monitoring of Expected Outcome
		How will outcome be monitored? HOW OFTEN will monitoring occur? HOW LONG will monitoring continue? ☐ Plan Year ☐ Until Expected Outcome is met

Participant/Legal Representative Initials_____ Page _____ of _____

NOTE: Full signature required on final page only. Initials required for all other pages.

Suspension



Reasons to stop the clock!

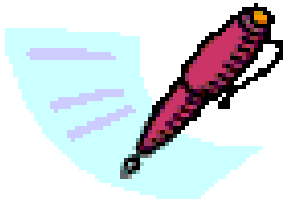
- A member is waiting on identification documents such as Birth Certificate, Photo ID and or Social Security Card.
- A member has been placed on waiting list for housing.

  (**after exhausting all housing options and resources**)

Medical/Program Denial

If the participant is deemed not program appropriate by OHCA, Living Choice staff will mail a letter of Program Denial to the participant and TC/CM Agency. The participant will have the right to a fair hearing should they appeal the decision. If the decision is upheld, the participant cannot re-apply until a year after the date of decision.

Withdrawal/Discharge Evaluation



If the participant wishes to withdraw or the TC/CM needs to discharge participant from the Living Choice Program …

- ✓ Only **one** reason for withdrawal/discharge must be checked
- ✓ Participant must sign *Withdrawal/Discharge Evaluation* only if they wish to withdraw from the Living Choice Program.

**TC/CM may then submit *Alternative Funds Request* for participant by the 5th of the following month.

Long Term Care Waiver Operations

☐**Living Choice** ☐**My Life; My Choice** ☐**Sooner Seniors** ☐**Medically Fragile**

WITHDRAWAL/DISCHARGE EVALUATION

Participant Name				
	Last	*First*	*MI*	*SoonerCare ID*

A. REASONS FOR WITHDRAWAL/DISCHARGE

Please select *only* one reason for MFP or Waiver participation ending:

☐ Death Cause of Death:_____ Date of Death:

☐ Moved out of state Date of move:

☐ Re-Institutionalization Date of Re-Institutionalization:

☐ Nursing Facility: ☐ Other Institution:

☐ Deterioration in Health/Mental Health/Cognitive Functioning

☐ Unable to Secure or Find Affordable Housing or Loss of Housing

☐ By request of Legal Guardian or Medical Decision-Making POA

☐ Service Needs exceed what can be provided in the community

☐ Changed Mind/Chose not to participate in care plan

☐ Financially Ineligible

☐ Move out of Nursing Facility prior to scheduled MFP transition

☐ Other (must specify): _____

B. WITHDRAWAL REQUEST

I request to withdraw from participation in the Living Choice Demonstration Project or Waiver Program.

Effective Date:

☐ I request termination of all TC/CM services.

☐ I have been informed that I may reapply at any time.

☐ I request referral to the following services:

1.
2.
3.

C. RIGHT TO A FAIR HEARING

I have been informed of my right to a fair hearing. I understand that I have the right to appeal any action of the Oklahoma Health Care Authority that I consider improper by sending my complaint, in writing, to:

Oklahoma Health Care Authority, 2401 NW 23rd Street, Suite 1A, Oklahoma City, OK 73107

Signature of Participant or Legal Agent	**Date**	**Signature of Witness**	**Date**
TC/CM Agency	**TC/CM Name**	**TC/CM Signature**	**Date**

Alternative Funds

Case is closed

- Withdrawal/Discharge Evaluation must be submitted within 3 working days
- Submit Alternative Funds Requests by 5th of the following month

LTCWO

- Review Alternative Funds Requests
- LTCWO will collaborate with agency biller on amount of units approved

TC/CM Biller

- Once approved units are submitted back to agency, the agency biller may submit 1 Invoice per month for Alternative Funds Requests
- Agency biller may submit 1 Invoice per month for QOL's

Non-Billable Case Units

Clerical Tasks

- Mailing, copying, filing, faxing and drive time
- Supervisory/Administrative Activities

Duplicative

- Services for tasks that may have already been billed

QOL Surveys

- QOL Surveys are paid separately at $100 per survey

Other

- Services outside the Fiscal Year
- Discrepancies in documentation
- Inter Agency Communications

LONG TERM CARE WAIVER OPERATIONS
ALTERNATIVE FUNDS REQUEST FORM

Fax form to Long Term Care Waiver Operations: (405) 522-7265

Participant Name				**SoonerCare ID**	
	Last	*First*	*MI*		

TC/CM: ***Please complete and attach supporting case notes.***

Agency: TC/CM:

Date of Service From: Date of Service To:

Total # of Units Requested: Code: ☐ Standard ☐ Very Rural Rate: $ 14.25

List Documents Obtained for Member (i.e. Birth Certificate, Photo ID, SSN) :

Cost to Obtain Documentation(s):

Total amount requested (total units requested + cost for docs obtained):

TC/CM Supervisor:

1. Has TC/CM submitted member's discharge/withdrawal form? ☐ Yes ☐ No
2. Has TC/CM attached progress note documentation supporting units requested? ☐ Yes ☐ No

Supervisor Name: Supervisor Signature: Date:

To be completed by Long Term Care Waiver Operations Staff

Date Received: Date Reviewed: LCP Coordinator:

Documentation Review

☐ Progress notes reviewed

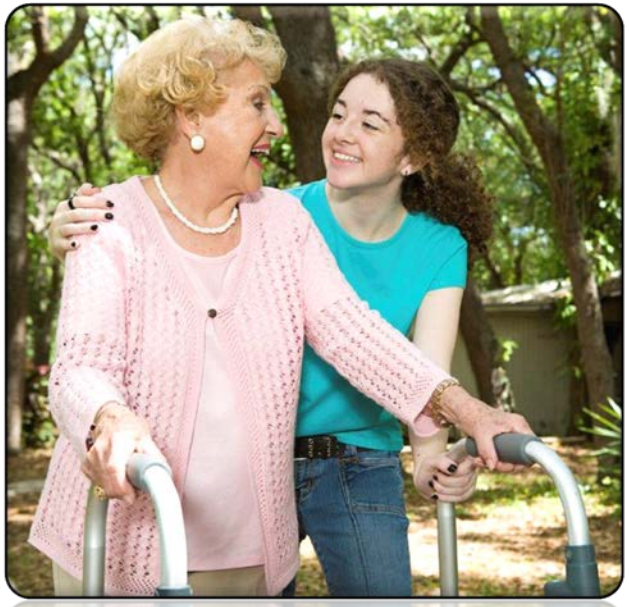
☐ Alternative Funds Request Form reviewed

☐ Additional information needed

Comments:

Total # of Units approved:
Total amount approved:
Invoice #

Medically Fragile
My Life, My Choice
Sooner Seniors



- 1915c Home and Community-Based Waivers

Medically Fragile

Medically Fragile, a 1915c Home and Community-Based alternative to placement in a hospital and/or skilled nursing facility allows Participant who qualify the opportunity to receive Medicaid-funded assistance for care in their home.

A medically fragile condition is defined as a chronic physical condition, which results in prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

1. There is a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision, and/or physician consultation and which in the absence of such supervision or consultation would require hospitalization.

2. The individual requires frequent, time consuming administration of specialized treatments which are medically necessary.

3. The individual is dependent on medical technology such that without the technology a reasonable level of health could not be maintained. Examples include but are not limited to dependence on ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.

Medically Fragile Referral

- Fax: 405-530-7185
- Website: www.okhca.org
- Mail:
  4345 N. Lincoln
  Oklahoma City, OK 73105

LONG TERM CARE WAIVER OPERATIONS
COMMON INTAKE FORM

Fax form to Long Term Care Waiver Operations: (405) 530-7265

Please Select a Program

☐ Living Choice Demonstration Program

☐ Medically Fragile Waiver Program

Personal Information

Last Name	First Name M.I.	Phone #
SoonerCare ID	Date of Birth	Age / Sex
Do you have a Legal Guardian? ☐ Yes ☐ No	If so, Who? Name:	Phone #
Do you have a Medical Decision Making Power Of Attorney? ☐ Yes ☐ No	If so, Who? Name:	Phone #

Institution Information

Name of Institution where you now live		Room #	Provider ID #	
Institution physical address	City	State	Zip	County
Institution director's name		Office Phone		
Personal physician's name	Admit Date	Length of stay in current facility:		

Person Making Referral:

☐ Self ☐ Family Member ☐ Nursing Facility ☐ Other

Name:	Agency/Relationship:	Phone #:

How did you hear about the Living Choice Project?

☐ Self ☐ Family Member ☐ Nursing Facility ☐ MDS 3.0 ☐ Other:

FOR OFFICIAL USE ONLY

Date Received:	Date forwarded to OU PAT:	Eligibility Determination Date:	Assigned to:

Medically Fragile Qualifying Criteria

- Member must be 19 years of age or older
- Member must reside and remain in the community
- Member must be deemed disabled and eligible for Medicaid and Long Term Care
- Financial eligibility is determined by the local OKDHS county office
- Member must receive a UCAT assessment to determine the Medical eligibility
- Member must meet Hospital and/or skilled nursing facility level of care
- Member must only be served in one waiver at a time

Medically Fragile Approved Services

Under the Medically Fragile Waiver Program, the following services are available to Oklahomans who qualify:

- Advanced Supportive/Restorative Care
- Case Management Services
- Environmental Modifications
- Home-Delivered Meals
- Hospice
- Institutional Transition Services
- Occupational Therapy
- Personal Care
- Prescription Drugs
- PERS (Personal Emergency Response System)
- Physical Therapy
- Private Duty Nursing
- Respiratory Therapy
- Respite Care
- Self-Direction Services
- Self-Directed Goods and Services (SD-GS)
- Skilled Nursing
- Specialized Medical Equipment and supplies
- Speech Therapy
- Transition Services

My Life, My Choice
Sooner Seniors

- MLMC and SS are both 1915c Home and Community-Based Waiver Programs designed to follow the Living Choice Demonstration allowing the Participant continued community living after the demonstration period providing that the participant continues to meet NF Level of care and financial eligibility

Program destinations are:

- Participant with a physical disability and who are 64 or younger will transition into MLMC

- Participant with chronic illnesses who are 65 and older will transition into SS

Approved Services

Under these Waiver Programs, the following services are available to Participant who qualify:

My Life, My Choice

- Adult Day Health
- Agency Companion
- Advanced Supportive/Restorative Assistance
- Assisted Living
- Assistive Technology
- Audiology (treatment and evaluation)
- Case Management
- Dental Services (up to $1,000 per person annually)
- Environmental Modifications
- Family Counseling
- Family Training
- Home Delivered Meals
- Hospice Care
- Independent Living Skills Training
- Institutional Transition Services
- Nutrition Services (evaluation and treatment)
- Prescription Drugs
- Personal Care
- Personal Emergency Response System (PERS)
- Psychiatry
- Psychological Services
- Respite Care
- Self Directed Goods and Services (SD-GS)
- Self Direction
- Skilled and Private Duty Nursing
- Specialized Medical Equipment and Supplies
- Therapy Services including Physical, Occupational, Speech and Respiratory
- Transportation
- Vision services

Sooner Seniors

- Adult Day Health
- Agency Companion
- Advanced Supportive/Restorative Assistance
- Assisted Living
- Case Management
- Dental services (up to $1,000 per person annually)
- Environmental Modifications
- Family Training
- Home Delivered Meals
- Hospice Care
- Institutional Transition Services
- Nutrition Services (evaluation and treatment)
- Prescription Drugs
- Personal Care
- Personal Emergency Response System (PERS)
- Private Duty Nursing
- Respite Care
- Self Directed Goods and Services (SD-GS)
- Self Direction
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Therapy Services including Physical, Occupational, Speech and Respiratory
- Transportation
- Vision services

Things to Remember

- Medically Fragile receives waiver transfers from DDSD, EPSDT/PDN and ADvantage. For more information on waiver transfers please contact the waiver coordinator
- Institutional Transitional Service is available to help waiver Participant return home from a NF or hospital stay
- Nutrition services are approved in three month increments; however, the prescription is required once a year
- Submit the IDT checklist with each initial/reassessment packet
- Case Management Monthly Monitoring Reports are due by the 5th of each month. This applies to My Life; My Choice, Sooner Seniors, Medically Fragile and Living Choice Participants who have transitioned into the community.

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

COMMUNITY SERVICE PLAN AUTHORIZATION REQUEST CHECKLIST

Participant Name				SoonerCare ID	
	Last	*First*	*Middle*		

☐ A. INITIAL ASSESSMENT

Pre-assessment

_____ Participant Consents and Rights
_____ Release of Information
_____ UCAT I & III
_____ Quality of Life Survey (QOL)

Post-assessment

_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan

STOP
This Section only pertains to The Living Choice Demonstration Program

☐ B. INITIAL COMMUNITY SERVICE PLAN

_____ Participant Consents & Rights
_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan
_____ UCAT (Parts I & III)
_____ Other, only if necessary for this plan (i.e. Nutritional Supplement, Environmental Mods)

☐ C. REASSESSMENT

_____ Participant Consents & Rights
_____ Release of Information
_____ Community Service Plan
_____ Community Service Plan Goals
_____ Community Service Back Up Plan
_____ UCAT (Parts I & III)
_____ Other, only if necessary for this plan (i.e. Nutritional Supplement, Environmental Mods)

☐ D. ADDENDUM

_____ Community Service Plan Addendum
_____ Revised Goal(s)
_____ Other, only if necessary for this plan

SIGNATURES

Documentation marked above was sent:

TC/CM Agency	TC/CM Signature	Date

LONG TERM CARE WAIVER OPERATIONS

☐**Living Choice** ☐**My Life; My Choice** ☐**Sooner Seniors** ☐**Medically Fragile**

IDT MEETING

Participant Name				**SoonerCare ID**	
	Last	*First*	*M.I.*		

Start	Stop	Time	Units

Signature **Title** **Relationship/Agency**

Agenda Goals:

1. Educated Participant to the philosophy, purpose and service the program provides. ☐ Yes ☐ No
2. TC/CM determined if other payment sources were available to purchase needed services prior to using Medicaid funding. ☐ Yes ☐ No

IDT Progress Notes:

The Participant has received the following information:

☐ Participant Assurances, Rights and Responsibilities
☐ Reporting Suspected Abuse, Neglect and Exploitation
☐ SoonerRide Brochure
☐ OKHCA Complaint/Grievance Form
☐ Request for a Fair Hearing Form
☐ Other _____ (i.e. agency brochure and agency orientation)

I,_____, have been given the above information. I have had the information explained to me and have been given the opportunity to ask questions so that I fully understand the information.

_____ _____
Member's Signature Date

_____ _____
TC/CM Signature Date

_____ _____
TC/CM Name (please print) TC/CM Agency

Total Units: _____

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Uniform Comprehensive Assessment, Part I
Intake and Referral

Numbers in parenthesis refer to item numbers in the Oklahoma Long-Term Care Authority (OLTCA) Manual.

Applicant information.

(1) **Indicate use of form**	(2) **Date completed (mo/day/year)**	(3) **Source of referral to this office List name, source, telephone - or - readmit**
Intake		
Screen and prioritization		
Comprehensive assessment		
Reassessment		
Referral out of this office		

Consumer information.

(4) Last name	First	MI	(8) Date of birth	
(5) Social Security number	Case number	Unique ID number	Area code	(9) Phone
(6) Street address	(7) City	State	Zip	

Additional sources of information.

(10) Last name	First	MI	Area code	(11) Phone
(12) Street address	City	State	Zip	

(13) Relation to consumer:

☐ Family, specify _____ ☐ Friend ☐ Hospital ☐ Other, specify _____

(14) Does the consumer know about this call or assessment interview? ☐ Yes ☐ No

(15) **(Ask)** What problems do you have right now that are causing you difficulty or what do you need assistance with? How long have you had these needs? What services are you receiving?

02HM003E-001

OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Uniform Comprehensive Assessment, Part III

Medical (Level of Care) Assessment

Assessment information.

(Assessor) Attach completed Form 02HM001E, Uniform Comprehensive Assessment, Part I, Intake and Referral. Numbers in parenthesis refer to item numbers in the Oklahoma Long-Term Care Authority (OLTCA) Manual.

(1) Consumer name		Date
Social Security number (2)	Case number	Unique ID number

(3) Location of: ☐ assessment ☐ reassessment
☐ consumer's residence ☐ relative's home ☐ nursing home
☐ hospital ☐ other, specify _____

Mental status questionnaire (MSQ)

(Assessor) Write responses to questions. Do not score until section is completed. Count one error for each incorrect response up to the maximum errors for the item. No response is counted as an incorrect response.

(4) **(Say)** I'm going to read you a list of questions. These are questions often asked in interviews like this and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with the current year.

Question	Answer	Maximum errors	Score	Weight	Weighted score
What year is it now?	_____	1	_____	X 4 =	_____
What month is it now?	_____	1	_____	X 3 =	_____

(Say) I'm going to give you a man's name and address to memorize and you will be asked to repeat the phrase later.

Memory phrase: **John Brown, 42 Market Street, Chicago**

Elicit three correct repetitions from the consumer, phrase by phrase or word by word, if necessary, before continuing.

(Ask) Without looking at a clock, what time is it? (within one hour)

Time is: _____ Response: _____ 1 _____ X 3 = _____

LONG TERM CARE WAIVER OPERATIONS

☐ **Living Choice** ☐ **My Life; My Choice** ☐ **Sooner Seniors** ☐ **Medically Fragile**

PARTICIPANT CONSENTS & RIGHTS

Participant Name				**SoonerCare ID**	
	Last	*First*	*MI*		

A. SERVICE SETTING

☐ I have decided to pursue participation in the Living Choice Project or Waiver Program to receive services in my own home. I understand that I may change my mind at any time during the process and decide not to continue with this service. (Proceed to Section B)

☐ I have decided **NOT** to pursue participation in the Living Choice Project or Waiver Program and to continue to receive services in the nursing facility. I understand that I may reapply at any time. (Proceed to Section D)

B. INFORMED CHOICE

The verbal selection of TC/CM agency has been obtained from the Participant. Please confirm or revise the following selections during Participant visit.

☐ I choose _____ as my TC/CM agency.
☐ I have no preference. Please select a provider for me.

☐ I choose to keep the previously chosen/assigned selection of TC/CM agency.
☐ I choose to select another TC/CM agency.

☐ I choose _____ (first choice) or _____ (second choice) as my in-home provider agency.
☐ I have no preference. Please select an in-home provider agency for me.

C. LEGAL GUARDIAN OR MEDICAL POWER OF ATTORNEY

I have a: ☐ Legal Guardian ☐ Medical Power of Attorney ☐ Neither (Proceed to Section D)

Name of Guardian/MPOA		
	Last	*First*

Address		Phone	
	Street *City* *Zip*		

D. RIGHT TO A FAIR HEARING

I have been informed of my right to a fair hearing. I understand that I have the right to appeal any action of the Oklahoma Health Care Authority that I consider improper by sending my complaint, in writing, to:

Oklahoma Health Care Authority
2401 NW 23rd Street, Suite 1A
Oklahoma City, OK 73107

E. SIGNATURES

Signature of Participant or Legal Agent Date *(If Participant signs with a mark, two witnesses are required.)*	Signature of TC/CM Date
Signature of Witness Date	Signature of Witness Date

LONG TERM CARE WAIVER OPERATIONS

☐ **Living Choice** ☐ **My Life; My Choice** ☐ **Sooner Seniors** ☐ **Medically Fragile**

COMMUNITY SERVICE PLAN

☐ **New** ☐ **Reassessment**

Participant Name				**SoonerCare ID**	
	Last	*First*	*M.I.*		

A. HOUSING INFORMATION (LIVING CHOICE PARTICIPANTS ONLY)

Housing Supplements (Check all that apply):

☐ Low-Income Housing Tax Credits
☐ HOME Dollars
☐ CDBG Funds
☐ Housing Choice Vouchers
☐ Housing Trust Funds
☐ Section 811
☐ 202 Funds
☐ USDA Rural Housing Funds
☐ Veteran's Affairs Housing Funds
☐ Funds for Home Modifications
☐ Funds for Assistive Technology related to Housing
☐ Other _____
☐ Not Applicable

Living Arrangements:

Will Participant live with family?
☐ Yes
☐ No

Housing Type:

☐ Home – owned by Participant
☐ Home – owned by family member
☐ Apartment – not assisted living
☐ Apartment – assisted living
☐ Group home of no more than 4 people

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

COMMUNITY SERVICE BACK-UP PLAN

Participant Name				SoonerCare ID #	
	Last	*First*	*M.I.*		

REQUIRED DOMAINS				
NOTE: Disaster-preparedness is not addressed in this document – See Disaster Preparedness Plan for actions related to disaster planning.				
List Specific Risks	**Tier I** Formal Support	**Tier II** Informal Support	**Tier III** Back-Up Support	**Tier IV** Extreme Emergency
Direct Care Assistance			Oklahoma 2-1-1 for 24-hour backup support	☐ 911 ☐ Other
Critical Health - Supportive Services			Oklahoma 2-1-1 for 24-hour backup support	☐ 911 ☐ Other

Participant/Legal Representative Initials_____

NOTE: Full signature required on final page only. Initials required for all other pages.

OKHCA Revised 1-1-2014

Discharge/Withdrawal

- TC/CM will notify providers to stop services
- TC/CM is responsible for verifying Participant Eligibility
- TC/CM must notify LTCWO of any re-institutionalizations so that we may properly document and submit to DHS for program line suspension or termination.

Long Term Care Waiver Operations

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

WITHDRAWAL/DISCHARGE EVALUATION

Participant Name				
	Last	*First*	*MI*	*SoonerCare ID*

A. REASONS FOR WITHDRAWAL/DISCHARGE

Please select *only* one reason for MFP or Waiver participation ending:

☐ Death Cause of Death:_____ Date of Death:

☐ Moved out of state Date of move:

☐ Re-Institutionalization Date of Re-Institutionalization:

☐ Nursing Facility: ☐ Other Institution:

☐ Deterioration in Health/Mental Health/Cognitive Functioning

☐ Unable to Secure or Find Affordable Housing or Loss of Housing

☐ By request of Legal Guardian or Medical Decision-Making POA

☐ Service Needs exceed what can be provided in the community

☐ Changed Mind/Chose not to participate in care plan

☐ Financially Ineligible

☐ Move out of Nursing Facility prior to scheduled MFP transition

☐ Other (must specify): _____

B. WITHDRAWAL REQUEST

I request to withdraw from participation in the Living Choice Demonstration Project or Waiver Program.

Effective Date:

☐ I request termination of all TC/CM services.

☐ I have been informed that I may reapply at any time.

☐ I request referral to the following services:

1.
2.
3.

C. RIGHT TO A FAIR HEARING

I have been informed of my right to a fair hearing. I understand that I have the right to appeal any action of the Oklahoma Health Care Authority that I consider improper by sending my complaint, in writing, to:

Oklahoma Health Care Authority, 2401 NW 23rd Street, Suite 1A, Oklahoma City, OK 73107

Signature of Participant or Legal Agent	**Date**	**Signature of Witness**	**Date**
TC/CM Agency	**TC/CM Name**	**TC/CM Signature**	**Date**

Long Term Care Waiver Operations

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

PROVIDER COMMUNICATION

Participant Name				
	Last	*First*	*M.I.*	*SoonerCare ID*

A. EVENT CHANGE

_____ Hospital Admission DATE

_____ Vacation Begin DATE

_____ Temp Nursing Facility Placement DATE

_____ Other Begin DATE (Please Specify) _____

_____ Suspension BEGIN DATE

_____ Hospital Discharge DATE

_____ Vacation End DATE

_____ Discharge DATE

_____ Other End DATE

_____ Suspension END DATE

B. ADDRESS CHANGE

Current Address				
	Street	***City***	***State***	***Zip***
New Address				
	Street	***City***	***State***	***Zip***

_____New Address effective DATE

_____Updated Phone Number (if necessary)

Type of qualified residence (Select one of the following):

- ☐ Home owned by participant
- ☐ Home owned by family member
- ☐ Apartment leased by participant, not assisted living
- ☐ Apartment leased by participant, assisted living
- ☐ Group home of no more than 4 people

Participant lives with family members:

- ☐ Yes
- ☐ No

C. TC/CM CHANGE

Current TC/CM			
New TC/CM		Effective Date	
Submitted by	**Agency**		**Date**

Critical Incident Evaluations/Investigations

Level I-Report within 1 working day of being made aware of incident

Level II- Report within 2 working days of being made aware of incident

Level III-Report within 2 working days of being made aware of incident

Please be aware of timely submissions

Addendums

Request must be submitted for increase of units and approved prior to depletion

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

CRITICAL INCIDENT REPORT: EVALUATION

Participant Name				SoonerCare ID	
	Last	*First*	*MI*		
Name of Person Reporting					

A. CRITICAL INCIDENT LEVELS AND EVENTS

Critical Incident Level	INCIDENT Please check box that describes incident.	Reporting Time Lines	Follow-Up Requirements
Level I – Urgent	☐ Sexual abuse ☐ Lost or missing person ☐ Questionable, unexpected or preventable death ☐ Suicide attempt ☐ Neglect* ☐ Physical abuse* ☐ Exploitation*	Within 1 working day	***Investigation Required.*** Report on investigation required.
Level II – Serious	☐ Involvement with the criminal justice system ☐ Restraint use ☐ Medication error with adverse effects ☐ Falls with injury	Within 2 working days	Evaluation required. ***May require investigation.*** If investigated, report on investigation required.
Level III – Significant	☐ Verbal abuse* ☐ Hospitalizations ☐ Emergency room visits	Within 2 working days	Evaluation required. ***May require investigation.*** If investigated, report on investigation required.

*** OKDHS/APS is the lead investigative authority in the event of critical events regarding abuse, neglect or exploitation.**

B. DETAILS OF INCIDENT

Date and Time of Incident:		Date Agency Aware of Incident:	
Witnesses to Incident:		Location of Incident:	

Description of Incident:

Action Taken and Outcome:

Did the Incident result in a change in the agency's Continuous Quality Improvement Plan? ☐ Yes ☐ No
If 'Yes' – has the change been implemented? Please comment:

Agency Investigation Required? ☐ No ☐ Yes ****If Yes: <u>Submit Critical Incident Investigation Report</u>**

Who was notified about this incident?
☐ OKHCA or Designee ☐ Supervisor/TC/CM ☐ Law Enforcement ☐ APS ☐ Legal Guardian ☐ Other (list)

C. SUPERVISORY REVIEW

Agency Supervisor has reviewed Critical Incident Report Evaluation: ☐ Yes ☐ No

Date Critical Incident Report Evaluation was reviewed? TC/CM Supervisor Signature:

Was Critical Incident a result of Back Up Plan failure? ☐ Yes ☐ No

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

CRITICAL INCIDENT REPORT: INVESTIGATION

Participant Name				SoonerCare ID	
	Last	*First*	*MI*		
Name of Person Reporting					

A. CRITICAL INCIDENT

(Describe Critical Incident)

B. EVIDENCE COLLECTED

(Describe evidence collected – Types of evidence include: testimonial; documentary; demonstrative, and physical)

C. ASSESSMENT OF EVIDENCE

(What is the root cause of the Critical Incident?)

D. CONCLUSIONS AND RECOMMENDATIONS

(What are your conclusions? What are your recommendations to resolve this issue and assure the Participant's future health and welfare?)

E. QUALITY IMPROVEMENT IMPLICATIONS

(How will the conclusions and recommendations from Section D enhance your organization's continuous quality improvement system?)

F. SUPERVISORY REVIEW

TC/CM Supervisor has reviewed Critical Incident Report Investigation: ☐ Yes ☐ No

Date Critical Incident Report Investigation was reviewed? TC/CM Supervisor Signature:

Comments:

LONG TERM CARE WAIVER OPERATIONS

☐Living Choice ☐My Life; My Choice ☐Sooner Seniors ☐Medically Fragile

COMMUNITY SERVICE PLAN ADDENDUM

Participant Name				SoonerCare ID	
	Last	*First*	*M.I.*		

REVISED SERVICES AND GOALS

Put Appropriate Amount for the Pay/Support Source: I=Informal; P=Private Pay; O=Other; M=Medicare; SP=State Plan; SC=Self Care

SERVICE/SUPPORT

Service line to be ended:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

Service line to be added:

Service Code	Type of Service	Service Provider	# of Units	Freq.	Units/ Year	Rate/ Unit	Begin Date	End Date	I	P	O	M	SP	SC	Program

GOALS

Expected Outcome	Action Steps	Monitoring of Expected Outcome
		How will outcome be monitored? HOW OFTEN will monitoring occur? HOW LONG will monitoring continue? ☐ Plan Year ☐ Until Expected Outcome is met

Participant/Legal Representative Initials_____ Page _____ of _____

NOTE: Full signature required on final page only. Initials required for all other pages.

Self Direction

Self-Directed Services are offered in the Long Term Care Waiver Operations for the Living Choice Demonstration and Waiver Programs that would grant the Participant an opportunity to control their personal care service delivery and their selection of providers.

TRANSITION TO SELF-DIRECTED SERVICES

Oklahoma Health Care Authority

Long Term Care Waiver Operations

☐**Living Choice** ☐**My Life; My Choice** ☐**Sooner Seniors** ☐**Medically Fragile**

RE: Member Name: _____Member ID: _____Phone# _____

The Member listed above is ready to transition to the Self-Directed Services Option.
Please proceed by following your agencies normal policies to request an amendment to add self-directed services to the member's service plan.

Authorization requirements include the following:

- The self-directed service line cannot precede the **date of this memo**. ***Please start the service plan approximately 2 weeks prior to the transition date to allow for corrections or changes***.
- The Case Manager and Supervisor reflected on Community Service Plan or Community Service Plan Addendum must have completed self-directed agent training.
- The Community Service Plan (6g) or Community Service Plan Addendum (6g) must reflect the correct number of units.
  The Self-Directed Budget Worksheet is located on the Morning Star Financial Services of Oklahoma Website: www.morningstarfs.com
- The number of units requested on the Service Plan or Addendum must correspond to the number of hours/units listed in the goals.
- The Service Plan Goals must define activities to be completed by the PCA or Direct Care Service worker including the approximate number of hours needed per week to complete each task.
- The PCA or Direct Care Service worker's Scheduling and Back-up Plan must be submitted with the Community Service Plan or Community Service Plan Addendum.
- The current provider agency **must** be notified of the closure date for the PCA.

If you have any questions, please feel free to call 405-522-7384.

Thank You

Avis Hill
LTCWO Division

OHCA SELF-DIRECTED SERVICES INTERNAL DOCUMENTS CHECKLIST

☐**Living Choice** ☐**My Life; My Choice** ☐**Sooner Seniors** ☐**Medically Fragile**

Participant Name				**SoonerCare ID**	
	Last	*First*	*M.I.*		

Initial Program Documents

_____ **Self-Assessment Survey**

_____ **Letter of Intent**

_____ **Member/Employer Roles and Responsibilities**

_____ **Acknowledgement of Informed Choice**

_____ **Designation of Authorized Representative**

_____ **Budget Calculation Worksheet**

_____ **Authorization to Transition to Self-Direction**

_____ **Goods and Services Expense Form**

_____ **Mileage Form**

Date Documents Received: _____

Case Management Agency: _____ Case Manager/TC: _____

Self-Directed Services Self-Assessment
Oklahoma Health Care Authority
Long Term Care Waiver Operations

Planning Your Services

Experience/Knowledge/Skill

I know when, where, and how I want all of my services delivered. ☐ **Yes** ☐ **No**

If no, please describe_____

I am able to train each employee who works with me on what assistance I need and how I want my services delivered. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident in my ability to monitor and communicate when I am satisfied or dissatisfied with my services. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident in my abilities to coordinate support from family, friends, and others including my employee to meet all of my assistance needs. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident in my ability to work with my Case Manager in planning for my self-directed services. ☐ **Yes** ☐ **No**

If no, please describe_____

Managing Your PCA

Experience/Knowledge/Skill

I have or can create a private and secure area in my home to maintain confidential employee records. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident in my ability to interview potential employees. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident in my ability to train employees. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident I can organize records, paperwork, and legal documents. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident in my ability to evaluate my employee's work performance. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident in my ability to fire an employee. ☐ **Yes** ☐ **No**

If no, please describe_____

I am confident in my ability to provide feedback to my employee to improve service performance. ☐ **Yes** ☐ **No**

If no, please describe_____

I am able to adjust my schedule with my employee as needed to meet my service needs. ☐ **Yes** ☐ **No**

If no, please describe_____

I am able to provide my employee with the necessary supplies and materials to complete all PSA/APSA tasks. ☐ **Yes** ☐ **No**

If no, please describe_____

I know what would cause me to fire an employee. ☐ **Yes** ☐ **No**

If no, please describe_____

Oklahoma Health Care Authority
Self-Directed Services

Mileage Reimbursement Request Form

Employee Name: _____ **Member Name:** _____

Date	Destination	Total Miles: To and From Destination	Total Amount (.56 per mile)
			0

***Mileage Reimbursement can not be claimed for the following:**

1. To and from Day Services
2. To and from supportive and competitive employment
3. Transporting school aged children to and from school

****Employee must have current automobile insurance. Vehicles used to transport members must have seat belts and must be used by the member at all times. Each vehicle must have first aid supplies.**

****Inaccurate or incomplete documentation will be returned for correction, which may result in delay of payments.**

Employee Signature:_____ **Date:**_____

Employer/Member Signature:_____ **Date:**_____

For OHCA Approval mail or fax to:

Attn: Long Term Care Waiver Operations

Oklahoma Health Care Authority

4345 North Lincoln

Oklahoma City, OK 73105

Phone: 888-287-2443

Fax: 405-530-7265

MEMBER/EMPLOYER ROLES and RESPONSIBILITIES
SELF-DIRECTED SERVICES
Oklahoma Health Care Authority
Long Term Care Waiver Operations

When a member chooses to Self-Direct in one of the following Long Term Care Waiver Operations programs: Living Choice; Sooner Seniors; My Life; My Choice; or Medically Fragile, they become the **employer** of the Personal Care Assistant, (PCA), and/or the Advanced Supportive Restorative Assistant (ASRA) and is responsible for the following:

- Recruits and interviews PCA/ASRA applicants
- Performs reference checks
- Selects and hires PCA/ASRA and determines their wages
- Maximum wage for PCA is _____
- Maximum wage for ASRA is _____
- Schedules, trains, and supervises the PCA/ASRA on delivery of services
- Monitors, communicates and evaluates the PCA/ASRA's work performance
- Discharges the PCA/ASRA as necessary
- Follows employment laws (applicable federal and state laws)
- Completes paperwork submitted to Morningstar FMS
- Meets all deadlines
- Tracks how many PCA hours are authorized and used according to budget worksheet. (Reports will be sent to members monthly by Morningstar FMS)
- Verifies employee "time worked" and signs timesheet
- Arranges all backup support and handles emergencies when PCA/ASRA is late or fails to show up for work.

Member Name: _____

Member Signature: _____ Date: _____

SELF-DIRECTED SERVICES
AUTHORIZED REPRESENTATIVE CONSENT
Oklahoma Health Care Authority
Long Term Care Waiver Operations

☐ **Living Choice** ☐ **My Life; My Choice** ☐ **Sooner Seniors** ☐ **Medically Fragile**

RE: Print Member Name: _____

Authorized Representative Name (Print) _____

Address_____

Telephone_____

Thank you for agreeing to assist the member referenced above with their employer responsibilities for Self-Directed Services.

As an authorized representative (AR) your role is to counsel and advise the member regarding any and all self-direction activities and decisions for which the member is responsible and take action on their behalf as directed by the member. **You may not be the PCA (personal care assistant) if you are the AR.**

By selecting the Self-Direction service option, the member is the employer of record and is responsible for the following:

- Recruit, hire and as necessary, discharge the personal care attendant
- Provide instruction and training to the personal care attendant on the tasks to be completed
- Develop the weekly work schedule based on the authorized service plan
- Determine the hourly wages
- Supervise the personal care attendant, document their time worked, and send timesheets to the fiscal reporting agent for payroll processing
- Provide tools and materials for work to be accomplished

As an authorized representative, you cannot make any decisions for or on behalf of the member or sign for the member unless you have a legal standing to do so.

If you should have any questions, you may contact the Long Term Care Waiver Operations (LTCWO) at 888-287-2443 and request to speak with a program coordinator.

If you have questions about employer or employee paperwork, payroll activity or timesheets, you may contact the reporting fiscal agent, Morningstar Financial Services at 1-866-537-8379. The customer service agent will verify the following information before they answer any of your questions.

- Member Medicaid ID#
- Member's address & phone #
- Last 4 digits of member's Social Security #
- Member's date of birth

AR Signature: _____ Date: _____

Member Signature: _____ Date: _____

☐ **Living Choice** ☐ **My Life; My Choice** ☐ **Sooner Seniors** ☐ **Medically Fragile**

SELF-DIRECTED SERVICES-LETTER OF INTENT

Oklahoma Health Care Authority

Long Term Care Waiver Operations

Participant Name				
	Last	*First*	*M.I.*	*SoonerCare ID*

The member listed above has selected the Self-Directed Services option and will submit an application for consideration.

In addition, **please remind the member that in order to prevent a delay or loss of payment to the PCA or Direct Service Worker, the following information has to be completed.**

- All **employer** paperwork must be correctly completed before it is sent to Morning Star FMS.
- All **employee** paperwork must be correctly completed before it is sent to Morning Star FMS.
- The background check for the employee must be completed by Morning Star FMS and is approved and clear.
- Self-Directed services have been authorized on the Service Plan.

If the Care Management Unit of the Oklahoma Health Care Authority requests additional information regarding a member's service plan, there may be a delay in authorization. The delay in authorization could affect the payroll for the employee.

If you have any questions, please feel free to contact the Living Choice or Waiver Program Coordinator at **888-287-2443.**

Self-Directed Services - Goods and Services Expense Form

Oklahoma Health Care Authority

Long Term Care Waiver Operations

Participant Name				
	Last	*First*	*M.I.*	*SoonerCare ID*

***Please check one**:

○ I have paid for this approved good or service and requesting reimbursement.
(Must attach receipt or proof of payment with $ amount.)

○ I have not paid for this good or service and requesting Morning Star to pay directly.

(Must attach estimate or bill with $ amount.)

***Make check payable to**:_____

***Mail Check to**: _____

Address**:** _____Phone #:_____

Social Security or Federal ID number (if applicable): _____
(For use on 1099 if necessary)

***Description of Goods/Services**	**Date**	**Amount ($)**
	Total Amount Due:	$ 0.00

***Specific Instructions/Comments:**

_____

_____

_____

*** Member/Employer's Signature:** _____

For OHCA Approval mail or fax to:
Attn: Long Term Care Waiver Operations
Oklahoma Health Care Authority
4345 North Lincoln Blvd
Oklahoma City, OK 73105

Fax: 405-530-7265
Phone: 888-287-2443

Acknowledgment of Informed Choice
Self-Directed Services
Oklahoma Health Care Authority
Long Term Care Waiver Operations

Living Choice ◯ **My Life; My Choice** ◯ **Sooner Seniors** ◯ **Medically Fragile** ◯

Participant Name				
	Last	*First*	*M.I.*	*SoonerCare ID*

Self-Directed Services are offered in the Long Term Care Waiver Operations (LTCWO) Living Choice Project and the Waiver Programs that gives you authority and control over who provides your Personal Care and Advanced Supportive/Restorative services and how these services are provided. This opportunity for self-direction and determination also requires you to assume additional responsibilities and perhaps additional risks that you do not have under the existing provider agency service that provides personal care services to you.

Acknowledgment of Responsibilities for Self-Directed Services

Please check **Yes or No** indicating your agreement with and acknowledgment of the following:

1.	**I have received and read the Self-Directed Information Handbook and understand what will be expected of me.**	☐ **YES** ☐ **NO**
2.	**I have completed the Self-Assessment Tool.**	☐ **YES** ☐ **NO**
3.	**I understand my Roles and Responsibilities in receiving Self-Directed Services.**	☐ **YES** ☐ **NO**
4.	**I am making a Voluntary and Informed Choice to receive Self-Directed Services.**	☐ **YES** ☐ **NO**
5.	**I understand that I may designate a family member or friend as an Authorized Representative to assist me in my employer responsibilities to the extent that I prefer.** ☐ **I understand that by choosing to designate an Authorized Representative that I do not give up any of my decision-making authority.** ☐ **I understand that an individual hired to provide Personal Care Services to me may not be my designated Authorized Representative.** ☐ **I understand that I may change my mind and revoke my designation of an Authorized Representative at any time by notifying my Case Manager and the FMS.**	☐ **YES** ☐ **NO**

Provider Opportunities

- New provider opportunities exist in each area of service for each of the waiver programs.
- The providers must be ADvantage certified to obtain a LTCWO Waiver contract.
- For inquiries on potential providers please contact:

Avis Hill, Senior Program Manager

405-522-7384

- Living Choice Advisory Committee, (LCAC) & Long Term Care Quality Initiatives Council, (LTCQIC)is the quality oversight forum that meets quarterly discuss different measures of performance, CIRs, and complaints.

Meetings

- Open to the Public -

Staff	Phone	Fax	E-Mail
Director			
Ivy Holt	405-522-7773	405-530-3230	ivoria.holt@okhca.org
Administrative Assistant			
Trudy Johnson-AA	405-522-7078	405-530-3275	trudy.johnson@okhca.org
Living Choice			
Essence McKnight - **Team Lead**	405-522-7682	405-530-7240	essence.mcknight@okhca.org
Patricia Linzy - RA	405-522-7367	405-530-3497	patricia.linzy@okhca.org
Irene Perez - PS	405-522-7739	405-530-7250	irene.perez@okhca.org
Waivers			
Avis Hill - WPM (supv)	405-522-7384	405-530-3253	avis.hill@okhca.org
Beverly Couch - SS	405-522-7534	405-530-3257	beverly.couch@okhca.org
Tatiana Reed – Med Frag	405-522-7270	405-530-7736	tatiana.reed@okhca.org
Shakina Johnson - MLMC	405-522-7402	405-530-7259	shakina.johnson@okhca.org
Quality			
David Ward – QM (supv)	405-522-7776	405-530-7722	david.ward@okhca.org
Mia Smith - PM	405-522-7329	405-530-7739	mia.smith@okhca.org
Stephen Neal-QI	405-522-7538	405-530-3426	stephen.neal@okhca.org

AA – Administrative Assistant
RA – Research Associates – Living Choice Program Coordinators
PS – Program Specialists

WPM – Waiver Program Manager (Supervisor)
MLMC – My Life; My Choice Waiver
SS – Sooner Seniors Waiver
MedFrag – Medically Fragile Waiver

QM – Quality Manager (Supervisor)
QI - Quality Intern
PM – Project Manager