

**Ohio Department of Medicaid
OHIO HOME CHOICE DEMONSTRATION PROGRAM
PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT
Pre-Transition Case Management Agency**

HOME Choice Operations Unit
P.O. Box 182709, 5th Floor
Columbus, Ohio 43218

(For State Use Only)

Provider Identification *(Please print or type entries)*

Agency Name				
Social Security or EIN Number *	Current or previous Medicaid Number(s) (if applicable)			

*You must attach a completed and signed W-9 form. Do not use GROUP tax ID number.

Service Location of Practice/Business

(Please complete an application for each physical location of practice or business. Non-agency providers can use home address if applicable)

Name/ Building Name/ or Department/ or In care of			
Physical Address <i>(Number, Street, Avenue or Route) (P.O. and Drop Boxes are not acceptable)</i>			Suite Number
City	County	State	Zip Code <i>(Zip +4, if possible)</i>
Telephone Number	Cell Phone Number	Email Address	

“Pay to” Address (Name & Address to which payment is to be mailed)

Leave blank if address is the same as “Service Location of Practice/Business”

Name		
Address		Suite Number
City	State	Zip Code <i>(Zip +4, if possible)</i>

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)

Leave blank if address is the same as “Service Location of Practice/Business”

Name			
Address			Suite Number
City	County	State	Zip Code <i>(Zip +4, if possible)</i>

Disclosure and Ownership/Control Interest Statement

1. List names, addresses, and SSNs for individuals serving in a leadership role (paid or volunteer).

Name	Address	SSN/EIN
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Name	Address	SSN/EIN	
Name	Address	SSN/EIN	
Name	Address	SSN/EIN	
Answer the following questions by checking “Yes” or “No”. If any of the questions are answered “Yes”, list names and addresses of individuals or corporations in spaces provided.			
2. Are any individuals serving in a leadership role (paid or volunteer) also the owner of other Medicare/Medicaid Agency? If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number. <input type="checkbox"/> YES <input type="checkbox"/> NO			
Name	Address	Provider (Title XIX Vendor) Number	
Name	Address	Provider (Title XIX Vendor) Number	
3. Have you or any individuals or organizations having a direct or indirect ownership or control interest of five (5) percent or more in the institution, organization, agency, or professional association been indicted or convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XX? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Name (who was it?)	Type of Offense and Disposition	When?	SSN/EIN
Name (who was it?)	Type of Offense and Disposition	When?	SSN/EIN
4. Have you or the Agency ever been sanctioned by the Medicare or Medicaid Program? <input type="checkbox"/> YES <input type="checkbox"/> NO If “YES”, when? (mm/dd/yyyy) How long? (mm/dd/yyyy) IF YES, ATTACH EXPLANATION			
Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN	
Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN	
5. Have you or any Directors, Officers, Agents, or Managing Employees of This Agency ever been indicted or convicted of a violation of State or Federal Law? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Name	Type of Offense and Disposition	When? Give date? (mm/dd/yyyy)	SSN/EIN
Name	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN

This amendment one to the provider agreement between the Ohio Department of Medicaid (ODM) and the undersigned Pre-Transition Case Management (“PTCM”) agency amends the agreement as follows: Pages one and two of the provider agreement remain the same. Starting on page three of the provider agreement, paragraphs one and two remain unchanged. The remainder of the agreement is replaced in its entirety with:

- A. Upon receiving a referral from ODM’s HOME Choice Operations Unit, the PTCM Agency shall:
1. Contact the institution and/or the applicant to schedule a face-to-face visit with the individual. This contact shall take place within 3 – 5 business days of receipt of the HOME Choice referral.
 2. Determine if the applicant has a guardian. If the applicant has a guardian, the PTCM Agency shall contact the guardian prior to scheduling the face-to face-meeting.
 3. Schedule and facilitate the face-to-face meeting with the individual/guardian within 10 business days of receipt of the HOME Choice referral.
- B. During the face-to-face meeting, the PTCM Agency shall:
1. Complete the HOME Choice Community Readiness Tool.
 2. Provide waiver information to the applicant/guardian and have the applicant/guardian sign the JFS 02399 “Request for Medicaid Home and Community Based Services (HCBS)” form if applicable. The completed form shall be submitted by the PTCM to the local JFS office for processing.
 3. Review the HOME Choice JFS 02362 “HOME Choice-Informed Consent” form with the applicant/guardian and obtain the applicant/guardian’s signature.
 4. Review the Qualified Residence fact sheet as it relates to HOME Choice eligibility criteria.
 5. Complete the JFS 02369 “HOME Choice Eligibility Checklist” form:
 - a. Based on the community readiness tool, dialogue, observations and other information shared, the PTCM shall provide comments on this form that reflect its professional opinion of whether the applicant should proceed with the HOME Choice process/program, not as a determination but as an observation.
 - b. Identify whether the PTCM Agency recommends approval for participation in the HOME Choice program by selecting the appropriate check box. (Please note that ODM’s HOME Choice Operations Unit will make the final determination).
 - c. Based on the community readiness tool, dialogue, observations and any other information shared, provide comments on the JFS 02369 “HOME Choice-Eligibility Checklist” form that reflect the PTCM Agency’s assessment of whether the applicant may be eligible to participate in a waiver program, not as a determination but as an observation. (For example: “Your health and safety cannot be assured by the program”; “Your needs can be met by community resources”.)
 6. Review the list of Transition Coordination Agencies with the applicant/guardian, taking into account the applicant’s disabilities and needs, and enter the applicant’s “preferred” choice of a Transition Coordination Agency onto the JFS 02365 “HOME Choice Demonstration and Supplemental Services Plan” form with the Transition Coordination Agency and Community Transition Services entered.
 7. Provide information regarding HOME Choice Services to the applicant, guardian, family, institution, and other appropriate individuals.
 8. Review with the applicant how Community Transition Services may be used, and the role of the Transition Coordinator with these funds in accordance with rule.
 9. Share additional community resources/living options with the applicant/guardian as may be appropriate when HOME Choice is not going to be recommended.
- C. Following the face to face meeting with the applicant, the PTCM Agency shall complete and submit the required documentation as follows:
1. Upon recommending approval of the applicant to the HOME Choice Program, the PTCM will submit the JFS 02369 “HOME Choice-Eligibility Checklist”, JFS 02362 HOME Choice-Informed Consent” form, Community Readiness Tool and JFS 02365 “HOME Choice Demonstration & Supplemental Services Plan” form to the HOME Choice Operations Unit. The PTCM Agency shall provide copies of these documents to the applicant/guardian, and maintain a copy of these documents in the applicant’s file.

2. When not recommending approval of the applicant to the HOME Choice Program, the PTCM Agency will submit the JFS 02362 “HOME Choice-Informed Consent” and/or JFS 02369 HOME Choice-Eligibility Checklist” form to the HOME Choice Operations Unit.

D. During the pre-transition period, the PTCM Agency shall:

1. Obtain regular status updates from the Transition Coordination Agency.
2. Schedule and participate in discharge planning meetings with the individual (referred to above as the “applicant”)/guardian, Transition Coordinator, discharge planners and others as requested by the individual .
3. Assist with linkages to service providers and community resources.
4. Fill out and submit to the HOME Choice Operations Unit a JFS 02371 “HOME Choice-Change in Status” form whenever there has been a change in the individual’s status that would affect their ability and/or willingness to participate in the program.
5. When applicable, make referrals to the local Behavioral Health (BH) agencies/providers and schedule a discharge planning meeting that includes the local BH team.
6. Assess what HOME Choice services should be added to the individual’s JFS 02365 “HOME Choice Demonstration & Supplemental Services Plan” form at time of discharge, contact service providers, coordinate service provision and submit updated HOME Choice Demonstration & Supplemental Service Plans to the HOME Choice Operations Unit as necessary.
7. Assist individuals with developing post-discharge back-up plans in the event of a failure of an authorized service to be provided.
8. Coordinate the individual’s discharge date to coincide with the start of the individual’s receipt of HCBS (waiver and/or state plan) and HOME Choice services.
9. Ensure that appropriate HOME Choice services are in place if waiver or state plan services cannot start at time of discharge.
10. Schedule and facilitate the final discharge planning meeting within two weeks prior to the individual’s discharge from the institution. The following shall be invited and expected to attend the final discharge planning meeting:
 - a. The individual/guardian,
 - b. HOME Choice Case Manager,
 - c. HOME Choice Transition Coordinator,
 - d. Nursing Facility Social Worker/Discharge Planner,
 - e. Behavioral Health providers if applicable,
 - f. HOME Choice service providers if applicable, and
 - g. Waiver providers if applicable

At the final discharge planning meeting, the discharge checklist shall be completed and representatives will sign off on assignments, coordinate final preparations for moving day, and agree on moving day participation and responsibilities.

E. At the time of the individual’s discharge from the institution, the PTCM Agency shall:

1. Transfer all pertinent information about the individual to the HOME Choice Case Manager
2. Communicate and coordinate with the individual, the Transition Coordination Agency and the HOME Choice Case Manager to ensure services and supports are in place and housing is “move-in” ready.
3. Provide necessary assistance with moving which may include:
 - a. Helping the individual move out of the institution;
 - b. Being available to assist the individual at the individual’s new home on move-in day.
4. Complete the JFS 02368 “HOME Choice-Enrollment Request” and submit to the HOME Choice Operations Unit within 24 hours of the individual’s discharge from the institution.
5. Submit an updated JFS 02365 “HOME Choice Demonstration and Supplemental Services Plan” form to the HOME Choice Operations Unit if additional HOME Choice services are needed post-discharge. The PTCM Agency shall contact service providers and coordinate service provision.

F. ODM, through its designee, shall pay the PTCM Agency for pre-transition case management services under this provider agreement as follows:

1. A payment of \$1,000.00 will be made to the PTCM Agency for each HOME Choice referral from ODM's HOME Choice Operations Unit that results in the initial face-to-face meeting. The expectation is that the PTCM Agency will complete the requirements described in paragraphs (A), (B) and (C) above. This payment of \$1,000.00 represents compensation for the PTCM Agency's completion of those requirements. In the event that the PTCM Agency does not complete the requirements described in paragraphs (A), (B) and (C), or if any payment under this provider agreement is made in error, ODM will recoup the payment by deducting the amount from a future payment.
2. A payment of \$1,000.00 will be made to the PTCM Agency for services performed during the pre-transition period including, at a minimum, those services identified in paragraph (D)(1) through (D)(5) above. This payment will be made upon ODM's HOME Choice Operations Unit's receipt of one of the following:
 - a. A completed JFS 02368 "HOME Choice-Enrollment Request" form ; or
 - b. A completed JFS 02371 "HOME Choice-Change in Status" form indicating the need for pre-enrollment termination along with documented evidence of the PTCM Agency having performed, at a minimum, the services identified in (D)(1) through (D)(5). This documentation must indicate the dates, times, location and service description of the specific PTCM work provided to the person after the initial face to face meeting.

G. The PTCM Agency agrees to comply with the terms of this provider agreement, along with federal and state laws, federal and state program requirements, and other requirements as required by ODM. The PTCM Agency also specifically agrees to:

1. Accept the allowable payments for pre-transition case management services as payment-in-full and not seek payment for the services from the resident, guardian, any member of the family, or any other person or entity.
2. Comply with data requests from ODM, including the provision of a complete data dictionary for electronic files.
3. Maintain all applicant/individual records necessary and in such form so as to fully disclose the extent of services provided for a period of six years from the date of payment based upon those records or until any initiated audit is completed, whichever is longer. At a minimum, each applicant/individual's record must contain:
 - a. A cover sheet that includes: name, address, and telephone number of the institution where the applicant resided, emergency contacts, guardianship information (if applicable), and name, address and phone number of the pre-transition case manager.
 - b. Case notes that include documentation of applicant/individual contacts and activities of the PTCM Agency on applicant's/individual's behalf. Nothing shall prohibit the use of technology-based systems in collecting and maintaining case note documentation. All case notes must be signed and dated. (Electronic entry/submission constitutes verification of a signature.)
 - c. Releases of information on HIPAA-compliant forms signed by the applicant/guardian.
 - d. Copies of the HOME Choice individual's service plans, forms, and any other documents related to the pre-transition process.
4. Furnish to ODM, the secretary of the Department of Health and Human Services, or the Health Care Fraud Section of the Ohio Attorney General, or their designees, any information maintained under paragraph 3 above for audit or any other purpose within 30 days of the request for such information. Audits may use statistical sampling. Failure to comply shall result in withholding of HOME Choice Demonstration Program payments and may result in termination from the HOME Choice Demonstration Program.
5. Inform the HOME Choice Operations Unit within thirty days of any changes to the information it provided in the Provider Enrollment Application / Time Limited Agreement (*e.g.*, change in ownership and/or control; change in Medicaid number; change in address; new phone number; etc.).

6. Have accurately disclosed in the application section on page two of this document PTCM ownership and control information, and the identity of any person with ownership or control interest (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX Services.
7. Comply with the criminal record check requirements, as applicable, set forth in Rules 5101:3-45-07, 5101:3-45-08, 5123:2-1-05, 5123:2-1-05.1, and in Chapter 173-9 of the Administrative Code.
8. Ensure that staff providing direct individual contact:
 - a. Have knowledge about and experience with local community resources and applicable disability laws and regulations.
 - b. Embrace individual self-determination and possess experience advocating on behalf of individuals with disabilities.
 - c. Are eighteen years of age or older.
9. Comply with the policies and procedures governing HOME Choice and the conditions of participation as set forth in Chapter 5101:3-51 of the Ohio Administrative Code.
10. Have accurately disclosed in the application section of this document that neither the PTCM Agency, nor any owner, director, officer of the PTCM Agency, is currently subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.

H. The HOME Choice Demonstration Program is not a Medicaid program. This agreement does not permit the PTCM Agency to furnish medical assistance services through the Ohio Medicaid Program.

I. This agreement supersedes any and all previous provider agreements for this service, whether written or oral, between the parties.

J. This agreement is intended to remain in effect for the duration of the HOME Choice Demonstration Program; however, the agreement may be terminated by either party upon written notice to the other party no less than 30 days prior to the termination date. The PTCM Agency, upon receipt of written notice of termination, shall immediately cease provision of services under this agreement unless otherwise directed by ODM.

K. The PTCM Agency, including any officer, member, employee or agent of the PTCM Agency, understands and agrees to take no action, or cause ODM to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws, including those provisions found in Chapter 102 and Chapter 2921 of the Ohio Revised Code.

L. The undersigned certifies that he/she is the officer, chief executive officer, or general partner of the organization that is applying to provide pre-transition case management services as part of the HOME Choice Demonstration Program. The undersigned agrees to be bound by this Provider Enrollment Application / Time Limited Agreement, and confirms that the information he/she has provided is true and accurate.

Name and Agency Name (<i>Please Print</i>)	
Signature	Date