

Oklahoma Living Choice Project

Form Instructions

INSTRUCTIONS for LCP1

Participant Consents and Rights

PURPOSE OF FORM

The LCP1 documents that the Nursing Facility Resident:

- a) Has received an orientation to the Living Choice Project;
- b) Has made the decision whether or not to participate in the Project.
- c) Has selected, or allowed OKHCA/Designee to select, providers for Transition Coordination and Home Care Provider services.
- d) Understands the right to appeal any action of the Oklahoma Health Care Authority regarding services or eligibility through a fair Administrative Hearing procedure.

HOW TO COMPLETE THE LCP1

PARTICIPANT INFORMATION

1. Review and validate the accuracy of the following information. If an error is discovered, draw one line through the inaccurate information and clearly print the correction.
 - a. Resident's County of Residence
 - b. Resident's Name
 - a. Last,
 - b. First,
 - c. Middle
 - c. Resident's SoonerCare ID number (9 digit unique identifier)
 - d. Resident's Address
 - a. Street,
 - b. City,
 - c. State
 - d. Zip

A. SERVICE SETTING

Explain to Resident

2. Explain the purpose of the Living Choice Project is to assist individuals living in a Nursing Facility who choose to live in the community.
3. Provide the Resident with an initial orientation to the Provider Agency and the Living Choice Project in a written, oral, audio or electronic media compatible with his/her desired form and/or communication skills.
4. Explain the care alternatives available to the Resident (nursing facility, in-home services, and Living Choice Project).
5. Explain that as a Living Choice Project Participant, he/she will be able to access an appropriate waiver program for which he/she qualifies at the end of the demonstration period.
6. Discuss with the Resident the inherent risks in choosing community living.
7. Explain the Resident can change his/her mind at any point. The Resident who chooses participation in the Living Choice Project may withdraw at any time. The Resident who chooses not to participate may reapply at any time.

Form

8. Check whether or not the Resident chooses to participate in the Living Choice Project.
9. If the Resident chooses to participate in the Living Choice Project, explain that he/she may withdraw from participation at any time.
10. If the Resident chooses not to participate in the Living Choice Project, explain that he/she may reapply at any time.

B. INFORMED CHOICE

11. Review and validate the accuracy of the Resident's choice of transition coordination agency.
12. Check whether the Resident chooses to either keep the previously chosen/assigned selection of transition coordination agency, or change to another provider. If the Resident chooses to change to another provider, complete the Participant Change of Provider form (LCP10).
13. Explain the role of the home care agency, and provide the Resident with information on available agencies in his/her service area.
14. Enter the Resident's first and second choice of home care provider, if applicable; or
15. Check if the Resident has no preference of home care provider and gives permission for a home care provider to be selected for him/her.

C. GUARDIAN OR POWER OF ATTORNEY

16. Check whether the Resident has a Guardian, a Power of Attorney, or Neither.
17. Enter the name of the Guardian or Power of Attorney, as applicable.
18. Enter the address of the Guardian or Power of Attorney, as applicable.

D. RIGHT TO A FAIR HEARING

19. Explain the Resident's right to appeal actions of the Oklahoma Health Care Authority concerning his or her services or eligibility through the Oklahoma Administrative Code hearing process.
20. Provide the Resident with a copy of the Request for a Fair Hearing form (13MP001E(H-1)).

SIGNATURES

21. Obtain Participant or Legal Representative's signature and date.
22. If Participant signs with a mark, obtain the dated signatures of two witnesses.
23. Transition Coordinator signs and dates form.

ROUTING

Transition Coordination Agency

1. If Resident does not choose to participate in the Living Choice Project, submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f) and Participant Consents and Rights (LCP1) via fax to Living Choice Project Administration.
2. If Resident chooses to participate in the Living Choice Project AND chooses to change to another transition coordination provider agency, complete and submit the Participant Change of Provider form (LCP10) and transfer Participant to chosen provider agency.
3. If Resident chooses to participate in the Living Choice Project with the current transition coordination agency, submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f), Transition Assessment Tool LCP23, and Service Team Release of Information (LCP5) via fax to Living Choice Administration.
4. Original documents are maintained in agency Participant file.

Living Choice Project Administration

1. Copies of all received documents are scanned to Participant file.

INSTRUCTIONS for LCP2

Voluntary Withdrawal Request

PURPOSE OF FORM

The LCP2 documents that the Living Choice Project Participant (or potential Living Choice Project Participant) voluntarily:

- a) withdraws from the Living Choice Project application process; or, requests termination of Living Choice Project services; and indicates any requests for referral to other service options; and
- b) understands the right to reapply for Living Choice Project services at any time.

HOW TO COMPLETE THE LCP2

Completed upon withdrawal from the application process. (completed by DHS)

Completed upon request for termination of services. (completed by Transition Coordinator)

PARTICIPANT INFORMATION

1. Enter the Participant's County of Residence
2. Enter the Participant's Name:
 - a. Last; b. First, c. Middle
3. Enter the Participant's Address:
 - a. Street, b. City, c. State, d. Zip
4. Enter the Participant's SoonerCare ID number (9 digit unique identifier)

A. WITHDRAWAL REQUEST

Form

5. Enter the name of the Transition Coordinator Agency serving the Participant.
6. Enter the name of the Transition Coordinator.
7. Mark all of the Participant's requests that apply at the time of withdrawal or termination (in cases of termination of services the Transition Coordinator should also complete the LCP15 Discharge Evaluation form).
8. The Participant, or person filling out the form, must write in the reason withdrawal is being requested.

Explain to Participant

9. Provide the Participant with information on available transition coordination and/or service agencies.
10. Indicate the name of the agency(s) to which the Participant requests referral(s).

SIGNATURES

Explain to Participant

11. Have the Participant (or legal representative) read the document and discuss any concerns to be sure it is understood and the selected service setting and transition coordination provider is correctly marked. *(If the Participant is unable to read the document, make arrangements to read or have it read to him or her.)*

Form

12. Have the Participant (or legal agent) sign and date the document.
13. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
14. Transition Coordinator signs and dates the form.

ROUTING

DHS

1. Original document to Living Choice Project Operations, 130 North Greenwood, Suite B, Tulsa, OK 74120.
2. Copy to DHS Participant file.

Living Choice Project Administration

3. Copy of documentation placed in Participant file.

INSTRUCTIONS for LCP5
Release of Information

PURPOSE OF FORM

The LC5 documents that the Living Choice participant authorizes the sharing of his or her medical and social information, including Medicare records (if applicable), for the purposes of planning, monitoring and evaluating his or her services and Living Choice Project compliance. Authorization is given for one year and includes: a) specified Participants of the participant's interdisciplinary service planning team, and b) authorized compliance monitoring agents of the Oklahoma Health Care Authority.

HOW TO COMPLETE THE LC5

PARTICIPANT INFORMATION

- 15. Enter the Participant's County of Residence
- 16. Enter the Participant's Name:
 - a. Last; b. First, c. Middle
- 17. Enter the Participant's Address:
 - a. Street, b. City, c. State, d. Zip
- 18. Enter the Participant's SoonerCare ID number (9 digit unique identifier)

A. AUTHORIZATION

Explain to Participant

- 19. Explain the purposes of the form to the Participant.

B. SERVICE TEAM MEMBERS

Form

- 20. Identify, in the spaces provided, the Participants of the Participant's interdisciplinary team who are being authorized to share information. The first team member is always the Oklahoma Health Care Authority.

SIGNATURES

Explain to Participant

- 21. Have the Participant (or legal representative) read the document and discuss any concerns to be sure it is understood and the selected service setting and transition coordination provider is correctly marked. *(If the Participant is unable to read the document, make arrangements to read or have it read to him or her.)*

Form

- 22. Have the Participant (or legal agent) sign and date the document.
- 23. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.

ROUTING

- 1. Transition Coordinator forwards a copy of the document to Living Choice Project Administration, 130 North Greenwood, Suite B, Tulsa, OK 74120.
 - 2. Copy to each provider/agency being authorized.
- Living Choice Project Administration**
- 3. Copy of documentation placed in Participant file.

INSTRUCTIONS for LCP6a1b

Request for Nutritional Supplement

PURPOSE OF FORM

The LCP6a1b documents the Participant's nutritional status to meet authorization guidelines and verifies that all required documentation is attached.

HOW TO COMPLETE THE LCP6a1b

PARTICIPANT INFORMATION

24. Enter the Participant's County of Residence
25. Enter the Participant's Name
 - a. Last,
 - b. First,
 - c. Middle
26. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
27. Enter the Participant's Address
 - a. Street,
 - b. City,
 - c. State
 - d. Zip

A. DESCRIPTION

28. Provides information regarding authorization guidelines for payment for nutritional supplement.

B. TYPE OF REQUEST

29. Check whether submission is a new request for nutritional supplement, a request for an extension of a currently authorized nutritional supplement, or a request to modify a currently authorized product type and/or quantity.

C. PRESCRIPTION

30. Check that physician's prescription is being submitted and attach prescription to form.
31. Enter product name that is documented on physician's prescription.
32. Enter Amount prescribed and Frequency to be ingested as documented on physician's prescription.
33. Enter Related Diagnosis as documented on physician's prescription.

D. CURRENT RELATED MEDICAL CONDITIONS

34. Check all health conditions that apply – include date of onset for each condition.
35. If nutritional supplement is being requested due to a health condition that is not listed, check the box labeled 'Other' and list the specific health condition(s) and date(s) of onset.
36. Describe any wounds by location and Stage or Type – include date of onset for each wound.

E. HEIGHT/WEIGHT INFORMATION

37. Enter Participant's current height and weight.
38. Enter the date on which the Participant was weighed.
39. Enter the Participant's Body Mass Index (BMI).
40. Check whether or not the Participant's BMI is below 21.
41. If Participant's BMI is below 21, skip to section F – authorization guideline has been met.
42. IF Participant's BMI is 21 or above, continue on to #3 in this section.
43. Enter Participant's previously documented weight.
44. Enter the document from which this weight was obtained. If other, please specify.
45. Enter the date of the Participant's previous weight.
46. Enter Total Pounds Lost as follows: Subtract the Participant's current weight from the previous weight and enter that number. (Example: A previous weight of 300# minus a current weight of 250# equals 50# weight

lost, or $300-250=50$)

47. Enter the % (Percentage) of body weight lost as follows: Divide Total Pounds Lost from previous step by Participant's previous weight. Multiply this number by 100. (Example: 50# weight loss divided by 300# previous weight equals 0.166. This number (0.166) multiplied by 100 equals 16.6% body weight lost, or $50/300=0.166 \times 100=16.6\%$)
48. Review the timeframe between the previous and current weights. Check if the Participant has experienced at least: a 10% loss in body weight over the previous 6 months; a 5% loss in body weight over the previous 30 days; or neither.

F. CORRESPONDING GOALS

49. Review required content for corresponding goals and check that goals have been attached.

G. ADDITIONAL SUPPORTING DOCUMENTATION

50. Include any additional documentation to support the Participant's need for nutritional supplement.

F. CORRESPONDING GOALS

51. Review required content for corresponding goals and check that goals have been attached.

SIGNATURES

52. Obtain signature and date of Participant or Legal Representative.
53. If Participant signs with a mark, obtain the dated signatures of two witnesses.
54. Transition Coordinator signs and dates form.

AUTHORIZATION GUIDELINES

55. Review authorization guidelines to ensure that appropriate documentation has been included.

ROUTING

5. Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f), Community Plan Addendum (LCP6e1), Request for Nutritional Supplement (LCP6a1b). and updated Service Team Release of Information form (LCP5) via fax to Living Choice Project Administration.
6. Original documents are maintained in agency Participant file.

INSTRUCTIONS for LCP6d1

Environmental Modification (EM) Decision Tool

PURPOSE OF FORM

The LCP6d1 documents: the Participant's identified need for environmental modification; the desired outcome/benefit and alternative resources/solutions explored by the Transition Coordinator

HOW TO COMPLETE THE LCP6d1

PARTICIPANT INFORMATION

24. Enter the Participant's County of Residence
25. Enter the Participant's Name:
 - a. Last; b. First, c. Middle
26. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
27. Enter the Participant's Address:
 - a. Street, b. City, c. State, d. Zip
28. Enter Service Plan Year

SECTION A

29. Enter description of environmental modification.
30. Enter by whom and the date, the need was identified.
31. Enter the anticipated outcome/benefit to the Participant for the proposed environmental modification.
32. Enter the homeowner's name
33. Enter the Property/landowner's name, if applicable.
34. Identify all alternative resources and solutions explored; include outcome/results of efforts.
35. Identify pay source of any previous environmental modifications (formal or informal) at this address.

SECTION B

36. Describe how the Participant's need for environmental modification is currently met.
37. Describe how the current situation fails to adequately meet Participant's needs.
38. Describe how the Participant's need for environmental modification can be met in alternative manner.
39. Describe less costly alternative solutions that might meet Participant's need.
40. Describe Participant's current evacuation plan.
41. Describe alternate bathrooms in residence (if applicable).
42. Describe alternate entrances/exits in residence (if applicable).
43. Indicate if Participant is able to enter/exit residence without assistance.
44. Indicate if Participant lives alone.
45. Indicate if Participant requires 24 hour supervision.
46. Indicate Participant's intent to remain at this residence.

SECTION C

47. Describe special equipment/assistive devices used by Participant.
48. Describe how environmental modification will meet needs of Participant.
49. Describe how environmental modification will allow Participant to function with great independence.
50. Describe how environmental modification will reduce Participant's risk for premature institutionalization.
51. Indicate Participant's agreement with proposed environmental modification.
52. Transition Coordinator signs, prints name/agency name and dates document.

ROUTING

1. Transition Coordinator keeps original document for the case file and forwards a copy to Living Choice Project Operations, 130 North Greenwood, Suite B, Tulsa, OK 74120.

INSTRUCTIONS for LCP6d2

Level of Function / Environmental Assessment

PURPOSE OF FORM

The LCP6d2 documents: the licensed therapist's evaluation of the Participant's current health status, level of function; assessment of the Participant's home and justification supporting environmental modification request.

HOW TO COMPLETE THE LCP6d2

PARTICIPANT INFORMATION

53. Enter the Participant's County of Residence
54. Enter the Participant's Name:
 - a. Last;
 - b. First,
 - c. Middle
55. Enter Participant's SoonerCare ID number (9 digit unique identifier).
56. Enter the Participant's Address:
 - a. Street,
 - b. City,
 - c. State,
 - d. Zip
57. Enter Participant's phone number/ gender / date of birth
58. Enter Name of Transition Coordination Agency and phone number.
59. Enter Transition Coordinator's name and Physician's name

A. HEALTH STATUS

60. Enter date of therapist's assessment
61. Enter primary diagnosis and date of onset.
62. Enter secondary diagnosis and date of onset.
63. Enter medical/surgical history.
64. Describe prior level of function.

B. CURRENT ASSESSMENT DATA

65. Describe strength – specify deficits.
66. Describe ROM status – specify deficits
67. Describe neurological status – specify deficits
68. Describe mobility – specify deficits
69. Describe gait.
70. Describe weight bearing status.
71. Describe pain rating: location – frequency – duration
72. Describe level of cognition
73. Describe posture.
74. Describe balance: sitting/standing – static/dynamic
75. Describe endurance
76. Describe skin
77. Describe sensation
78. Describe level of vision
79. Describe level of coordination
80. Describe hearing deficits
81. Describe proprioception
82. Identify assistive/adaptive equipment available to and used by Participant

C. ENVIRONMENT ASSESSMENT

83. Describe how Participant enters/exit the home.

84. Describe alternative entrances/exits to the home.
85. Measure and record width of current wheelchair and/or walker, if applicable.
86. Measure and record door clearance at proposed environmental modification site(s).
87. Measure and record length, width, depth, condition of existing porch(es)/ramp(s).
88. Record location, number, type and height of existing steps.
89. Describe location of handrail(s) or other support structures.
90. Identify precautions/safety concerns.
91. Identify minimum clear floor space in bathroom(s), if applicable.
92. Identify alternate bathroom(s), if applicable.
93. Describe how Participant's bathing/toileting needs are currently met, if applicable.

D. JUSTIFICATION OF ENVIRONMENTAL MODIFICATION(S) REQUEST

94. Describe how Environmental Modification will allow Participant to function with great independence.
95. Describe how Environmental Modification will assure Participant's health, welfare and safety.
96. Describe Participant's risk for premature institutionalization without environmental modification.
97. Enter additional comments.
98. Therapist signs, prints name/agency name and dates document.

INSTRUCTIONS for LCP6d3

Environmental Modification Permission and Verification

PURPOSE OF FORM

The LCP6d3 – Section A – Identifies property ownership. Section B - obtains permission from the property owner to make the proposed permanent modification(s) to the Participant's residence AND – Section C – provides confirmation from the Participant and Transition Coordinator, that product/services have been constructed or delivered and installed by the authorized Provider.

HOW TO COMPLETE THE LCP6d3

PARTICIPANT INFORMATION

99. Enter the Participant's County of Residence
100. Enter the Participant's Name:
 - a. Last;
 - b. First,
 - c. Middle
101. Enter the Property Address of Participant's residence:
 - a. Street,
 - b. City,
 - c. State,
 - d. Zip
102. Enter the Participant's SoonerCare ID number (9 digit unique identifier)

A. PROPERTY OWNERSHIP

103. Indicate if property is owned by Participant.
104. Enter name of Environmental Modification Provider.

B. PROPERTY MODIFICATIONS

105. Enter complete description of proposed, permanent modification(s) to property.
106. Property owner reads Section B and signs and dates the document.
107. Enter printed name of property owner.

C. VERIFICATION OF SERVICE DELIVERY

108. Enter the Environmental Modification Provider name
109. Enter the Provider ID number
110. Enter Service Completion Date.
111. Participant reads Section C, signs and dates the document.
112. If Participant signs with a mark; obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
113. Transition Coordinator signs, prints name and dates the document.

ROUTING

2. Transition Coordinator keeps original document for the case file and forwards a copy to:
Living Choice Project Operations, 130 North Greenwood, Suite B, Tulsa, OK 74120.

INSTRUCTIONS for LCP6e1

Community Plan Addendum

PURPOSE OF FORM

The LCP6e1 documents changes to the Participant's Living Choice Community Plan.

HOW TO COMPLETE THE LCP6e

PARTICIPANT INFORMATION

56. Enter the Participant's County of Residence
57. Enter the Participant's Name
 - a. Last,
 - b. First,
 - c. Middle
58. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
59. Enter the Participant's Address
 - a. Street,
 - b. City,
 - c. State
 - d. Zip
60. Enter the Participant's Date of Birth (MM/DD/YYYY)

REVISED SERVICES/SUPPORT – SERVICE LINE TO BE ENDED/ADDED

SERVICE LINE TO BE ENDED:

61. Enter the date of the most recent LCP6g from which the service line data is copied.
62. If there is no service line to be ended or corrected, draw one line through this row and proceed to step 18.
63. Service Code – List Living Choice Project and/or State Plan services by assigned Service Code with any related Modifier(s). Leave box blank for non-Medicaid and informal services/supports.
64. Type of Service – Enter the title, name or description of the service/support (e.g., Personal Care, Meals, medications, etc.).
65. Service Provider – Enter the full name of the agency or person providing each service/support.
66. # of Units – Enter the number of units of service to be provided for each service/support. (For medications, enter State Plan for the first 3 prescriptions and Living Choice for prescriptions starting at the 4th.)
67. Freq – Abbreviate how often the # of Units will be provided: daily (D); weekly (W); monthly (M); or yearly (Y).
68. Units/Year – Enter the total number of units of the service projected for the entire year. Use the following formula: multiply # of Units X Freq X how often the frequency occurs in a year (daily = 365, weekly = 52, monthly = 12, yearly = 1).
69. Rate/Unit – Enter the reimbursement rate per unit for each service. Use Living Choice Project rates for Living Choice Project services, Medicare rates for Medicare services, etc. (For medications, regardless of the actual cost, enter the current rate per prescription per Medicaid Policy for current year.)
70. Begin Date – Enter the service line begin date as documented on the LCP6g.
71. End Date – Enter the date service line is to be ended. **NOTE: If the service line needs to be deleted due to error, the Begin Date and End Date should be the same. Enter the corrected service line as directed in 'Service Line to Be Added' section.**
72. For each service, check the box that designates the appropriate pay/support source. (Definitions: Informal = unpaid services by family or friends; Private Pay = services paid by the Participant or other individual, *but not* by an organized community agency or private insurer; Other = costs borne by an organized community agency or private insurer; Medicare = service paid by federal insurance entitlement; State Plan = regular state Medicaid (Title XIX) services; Self Care = activities managed/completed by the Participant; Living Choice = services paid by the Living Choice Demonstration Project.)

SERVICE LINE TO BE ADDED

73. If there is no service line to be ended or corrected, draw one line through this row and proceed to 'Goals' section.
74. Enter Service Code, Type of Service, Service Provider, # of Units, Freq, Units/Year, Rate/Unit as instructed in steps 8 through 14.
75. Begin Date – Enter date the service line is to begin.
76. End Date – Enter date the service line is to end.
77. Check the box that designates the appropriate pay/support source as instructed in step 17.

GOALS: EXPECTED OUTCOME AND ACTION STEPS

78. Enter the Expected Outcome(s) to be achieved for each Service/Support line in order to meet the Long Term Goal. These should be measurable and time specific.
 79. Enter all Action Step(s) necessary to meet each Expected Outcome. Action Steps should be measurable and time specific. Action Steps should address completely the corresponding service line(s). Instructions to modify previous goals are unacceptable (i.e., delete steps B, D, F from previous goals).
- Note: There may be instances when goals are written without a corresponding service line. However, a change in service line(s) always requires corresponding goals.

GOALS: MONITORING OF EXPECTED OUTCOME

- Monitoring of Expected Outcomes is based upon the services/supports, strengths, challenges and needs of the Participant. Type, frequency and duration of monitoring activities should be individualized to address the specific needs of the Participant.
80. Enter HOW each Expected Outcome will be monitored (phone calls, home visits, etc.).
 81. Enter HOW OFTEN the indicated monitoring contact(s) will occur (daily, weekly, monthly, etc.).
 82. Check HOW LONG the monitoring frequency will continue. (End Date of _____ = specific end date by which Expected Outcome is to be achieved; Plan Year = throughout the remainder of the Project Plan Year; Until Expected Outcome is met = ongoing until outcome is achieved.)

SIGNATURES

83. Have the Participant initial all pages of the Community Plan Addendum except for the final page.
84. Enter page number and total number of pages on each page.
85. Have the Participant (or legal representative) review the Community Plan Addendum to verify understanding and accuracy. Discuss any questions and/or concerns, and make any necessary changes. Have the Participant check whether or not he/she agrees to the Plan.
86. Have the Participant or legal representative sign and date the document on the final page.
87. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
88. Enter any supporting documentation.
89. Enter the date the Community Plan Addendum is submitted.
90. Print or type the Transition Coordinator name.
91. The Transition Coordinator signs his/her legal signature.
92. The Transition Coordinator Supervisor signs his/her legal signature.
93. Enter the name of the Transition Coordination Agency.

ROUTING

Transition Coordination Agency routing of Community Plan Addendum

7. Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f), Community Plan Addendum (LCP6e1), and any other required documents via fax to Living Choice Project Administration.
8. Original documents are maintained in agency Participant file.

Living Choice Project Administration

2. Authorized Plan (LCP6g) is copied to the Transition Coordination agency and any additional providers authorized by the Addendum.
3. Copies of all received documents are scanned to Participant file.

Transition Coordination Agency routing of Authorized Plan

1. Copy of Authorized Plan (LCP6g) provided to Participant.
2. Copy of Authorized Plan (LCP6g) maintained in agency Participant file.

INSTRUCTIONS for LCP6e2

Request for Grab Bar(s)

PURPOSE OF FORM

The LCP6e2 documents the number, cost and location of needed grab bars for bathroom installation, verifies who will manage installation, and obtains permission from the owner to make the indicated permanent modifications to the Participant's residence.

HOW TO COMPLETE THE LCP6e2

PARTICIPANT INFORMATION

94. Enter the Participant's County of Residence
95. Enter the Participant's Name
 - a. Last,
 - b. First,
 - c. Middle
96. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
97. Enter the Participant's Address
 - a. Street,
 - b. City,
 - c. State
 - d. Zip

A. LOCATION OF BATHROOM INSTALLATION(S)

98. Enter the specific location in the bathroom where each grab bar is to be installed.
99. Enter the cost for each grab bar (cost of installation is to be included with the cost of the grab bar).
100. Enter the total cost for all grab bars.
101. Include any supporting documentation in the Comments section.

B. DME PROVIDER

102. Enter the name of the DME company who will install the requested grab bar(s).

C. HOMEOWNER INFORMATION

103. Check whether or not the Participant owns the property to be modified.
104. Document the reason the homeowner is unable to provide/install the requested grab bar(s).

D. SIGNATURES

105. Have the property owner read the document and discuss any concerns to be sure it is understood.
106. Obtain the owner's signature and date.
107. Enter the printed name of the owner.
108. Transition Coordinator signs and dates the form.
109. Enter the printed name of the Transition Coordinator.

ROUTING

9. Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f), Community Plan Addendum (LCP6e1), Request for Grab Bar(s) (LCP6e2). and updated Service Team Release of Information form (LCP5) via fax to Living Choice Project Administration.
10. Original documents are maintained in agency Participant file.

INSTRUCTIONS for LCP6e3

Request for Personal Emergency Response System Request

PURPOSE OF FORM

The LCP6e3 documents the fall history, living arrangements, and mental status of the Participant to meet authorization guidelines; reviews alternatives explored, and verifies attachment of the required Disease Management and Fall Prevention plans.

HOW TO COMPLETE THE LCP6e3

PARTICIPANT INFORMATION

- 110. Enter the Participant's County of Residence
- 111. Enter the Participant's Name
 - a. Last, b. First, c. Middle
- 112. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
- 113. Enter the Participant's Address
 - a. Street, b. City, c. State d. Zip

A. FALL HISTORY

- 114. Enter the date and circumstances of the Participant's most recent fall.
- 115. Enter the approximate frequency that the Participant experiences falls (weekly, monthly, yearly, etc.).

B. LIVING ARRANGEMENTS

- 116. Check whether or not the Participant lives alone.
- 117. If the Participant does not live alone, document the Participant's living arrangements and the approximate amount of time the Participant is routinely left alone.

C. MENTAL STATUS ASSESSMENT

- 118. Enter the Participant's most recent MSQ score.
- 119. Enter the date the MSQ was assessed.
- 120. Check whether or not the Participant is able to describe appropriately how and when to use the PERS.
- 121. Check whether or not the Participant is physically able to use the PERS.
- 122. Enter any supporting documentation. If MSQ is > 18, additional documentation is required to support the need for the PERS.

D. REVIEW OF ALTERNATIVES

- 123. Document the reasons that identified alternatives to PERS are ineffective in meeting the Participant's needs.

E. FALL PREVENTION AND DISEASE MANAGEMENT

- Review instructions indicating requirement for Disease Management and Fall Prevention Plans, then:
- 124. Check that Disease Management Plan has been included and attach to form.
 - 125. Check that Fall Prevention Plan has been included and attach to form.

SIGNATURES

126. Obtain Participant or Legal Representatives signature and date.
127. If Participant signs with a mark, obtain the dated signatures of two witnesses.
128. Transition Coordinator signs and dates form.

ROUTING

11. Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f), Community Plan Addendum (LCP6e1), Personal Emergency Response System Request (LCP6e3), and updated Service Team Release of Information form (LCP5) via fax to Living Choice Project Administration.
12. Original documents are maintained in agency Participant file.

INSTRUCTIONS for LCP6e

Community Plan

PURPOSE OF FORM

The LCP6e documents overall services and supports and serves as the authorization request for Living Choice Project services.

HOW TO COMPLETE THE LCP6e

PARTICIPANT INFORMATION

129. Enter the Participant's County of Residence
130. Enter the Participant's Name
 - a. Last,
 - b. First,
 - c. Middle
131. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
132. Enter the Participant's Address
 - a. Street,
 - b. City,
 - c. State
 - d. Zip
133. Enter the Participant's Date of Birth (MM/DD/YYYY)

HOUSING INFORMATION

134. Check all housing supplements received by the Participant. If 'Other' is checked, please specify. Check 'Not Applicable' if no housing supplements were received.
135. Check whether or not Participant will live with family.
136. Check the type of housing into which Participant is transitioning.

LONG TERM GOAL

137. Enter the Participant's Long Term Goal.

SERVICES/SUPPORTS

Enter all formal, informal and self care services/supports in Service/Support rows:

138. Service Code – List Living Choice Project and/or State Plan services by assigned Service Code with any related Modifier(s). Leave box blank for non-Medicaid and informal services/supports.
139. Type of Service – Enter the title, name or description of the service/support (e.g., Personal Care, Meals, medications, etc.).
140. Service Provider – Enter the full name of the agency or person providing each service/support.
141. # of Units – Enter the number of units of service to be provided for each service/support. (For medications, enter State Plan for the first 6 prescriptions and Living Choice for prescriptions starting at the 7th.)
142. Freq – Abbreviate how often the # of Units will be provided: daily (D); weekly (W); monthly (M); or yearly (Y).
143. Units/Year – Enter the total number of units of the service projected for the entire year. Use the following formula: multiply # of Units X Freq X how often the frequency occurs in a year (daily = 365, weekly = 52, monthly = 12, yearly = 1).
144. Rate/Unit – Enter the reimbursement rate per unit for each service. Use Living Choice Project rates for Living Choice Project services, Medicare rates for Medicare services, etc. (For medications, regardless of the actual cost, enter the current rate per prescription per Medicaid Policy for current year.)
145. For each service, check the box that designates the appropriate pay/support source. (Definitions: **Informal** = unpaid services by family or friends; **Private Pay** = services paid by the Participant or other individual, *but not* by an organized community agency or private insurer; **Other** = costs borne by an organized community agency or private insurer; **Medicare** = service paid by federal insurance entitlement; **State Plan** = regular state Medicaid (Title XIX) services; **Self** = activities managed/completed by the Participant; **Living Choice** = services paid by the Living Choice Demonstration Project.)

GOALS – EXPECTED OUTCOMES AND ACTION STEPS

Expected Outcomes and Action Steps

146. Enter the Expected Outcome(s) to be achieved for each Service/Support line in order to meet the Long Term Goal. These should be measurable and time specific.
147. Enter the Action Step(s) necessary to meet each Expected Outcome. These should be measurable and time specific.
148. In the event a Goal is needed without a corresponding Service/Support, draw one line through the Service/Support row and document the goal as noted above.

GOALS – MONITORING OF EXPECTED OUTCOMES

Monitoring of Expected Outcomes is based upon the services/supports, strengths, challenges and needs of the Participant. Type, frequency and duration of monitoring activities should be individualized to address the specific needs of the Participant.

149. Enter HOW each Expected Outcome will be monitored (phone calls, home visits, etc.).
150. Enter HOW OFTEN the indicated monitoring contact(s) will occur (daily, weekly, monthly, etc.).
151. Check HOW LONG the monitoring frequency will continue. (End Date of _____ = specific end date by which Expected Outcome is to be achieved; Plan Year = throughout the remainder of the Project Plan Year; Until Expected Outcome is met = ongoing until outcome is achieved.)

MONITORING PROGRESS TOWARD SUCCESSFUL COMMUNITY INTEGRATION

The monitoring plan is developed in collaboration with the Participant. Type, frequency and duration of monitoring activities are individualized to address the specific needs of the Participant. It is recommended to include intensive monitoring during the first week(s) the Participant is in the community.

152. Type of Monitoring Visit – Enter the type of monitoring contact(s) to be completed for a specific time frame (phone call, home visit, etc.).
153. Frequency and Timeframe for Monitoring – Enter how often the indicated type of monitoring contact(s) will occur, and for how often (daily for 1 week, weekly for 1 month, etc.).
154. Outcomes – Enter the Participant's stated outcome(s) by which successful community transition will be measured.

VERIFICATION

155. Have the Participant (or legal representative) review the Community Plan to verify understanding and accuracy. Discuss any questions and/or concerns, and make any necessary changes. Have the Participant initial when in agreement with the plan.
156. Provide and review with the Participant a list of available program services and provider agencies. Have the Participant initial when this activity has been completed.

SIGNATURES

157. Have the Participant initial all pages of the Community Plan except for the final page. Also enter page number and total number of pages on each page.
158. Have the Participant or legal representative sign and date the document on the final page.
159. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
160. Enter any supporting documentation.
161. Enter the date the Community Plan is submitted.
162. Enter the anticipated Institutional Discharge Date. This date serves as the begin date for the Community Plan.
163. Enter the date Personal Care Services are scheduled to begin.
164. Print or type the Transition Coordinator name.
165. The Transition Coordinator signs his/her legal signature with date.

166. The Transition Coordinator Supervisor signs his/her legal signature with date.
167. Enter the name of the Transition Coordination Agency.

ROUTING

Transition Coordination Agency routing of Community Plan

13. Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f), Community Plan (LCP6e), Community Back Up Plan (LCP25), RN Assessment (LCP6), UCAT, and updated Service Team Release of Information form (LCP5) via fax to Living Choice Project Administration.
14. Original documents are maintained in agency Participant file.

Living Choice Project Administration

4. Authorized Plan (LCP6g) is copied to the Transition Coordination agency and all authorized providers.
5. Copies of all received documents are scanned to Participant file.

Transition Coordination Agency routing of Authorized Plan

3. Copy of Authorized Plan (LCP6g) provided to Participant.
4. Copy of Authorized Plan (LCP6g) maintained in agency Participant file.

INSTRUCTIONS for LCP6f

Community Plan Authorization Request Checklist

PURPOSE OF FORM

The LCP6f confirms that complete packets of the documents required for authorization of an initial Living Choice Community Plan or Community Plan Addendum were forwarded by the Transition Coordinator and were received by the Living Choice Program or its agent.

HOW TO COMPLETE THE LCP6f

PARTICIPANT INFORMATION

- 168. Enter the Participant's County of Residence
- 169. Enter the Participant's Name
 - a. Last, b. First, c. Middle
- 170. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
- 171. Enter the Participant's Address
 - a. Street, b. City, c. State d. Zip

A. INITIAL ASSESSMENT DOCUMENTS

Form

- 172. Check 'A' if documents being submitted are components of the Initial Assessment packet.
- 173. Enter the number of pages of each item being sent in the blank space to the left of each item. Leave space blank or enter 'Ø' if an item is not being submitted.

B. INITIAL COMMUNITY PLAN

Form

- 174. Check 'B' if documents being submitted are components of the initial Community Plan packet.
- 175. Enter the number of pages of each item as directed in Step 6.

C. ADDITIONAL DOCUMENT TYPE

Form

- 176. Check 'C' when submitting any additional documents. Indicate related category of documentation by checking the appropriate type of submission:
 - a. Initial Assessment Packet – Check box when documents are included as a part of the Initial Assessment Packet, such as a Change of Provider form.
 - b. Initial Community Plan Packet – Check box when documents are included as a part of the Initial Community Plan Packet, such as a Request for Nutritional Supplement.
 - c. Community Plan Addendum – Check box when submitting an addendum and related documents.
 - d. Response to Condition or SPR – Check box if documents are submitted in response to a Condition or SPR. List related Community Plan issue.
 - e. Additional Information – Check box when documentation is submitted for informational purposes only.
- 177. Enter the number of pages of each item as directed in Step 6.

D. PRIORITY

- 178. Check 'D' **ONLY** when there is a documented Participant health and/or safety emergency that requires Community Plan authorization within 24 hours.
- 179. Enter the reason for the priority request.

SIGNATURES

180. Enter the name of the Transition Coordination Agency.
181. Transition Coordinator signs and dates form.

ROUTING

Transition Coordination Agency

15. Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f) and any related documents via fax to Living Choice Project Administration.
16. Original documents are maintained in agency Participant file.

Living Choice Project Administration

Complete 'LCP Use Only' area:

6. Count number of pages of each item received. Check box to confirm receipt. If there is a discrepancy between pages documented as submitted and pages actually received, document the number of pages received in the blank space.
7. Enter initials in adjacent column after confirmation is completed for each section.
8. Copies of all received documents are scanned to Participant file.

INSTRUCTIONS for LCP9

Provider Communication

PURPOSE OF FORM

The LCP9 is a communication tool to be used to inform either LTCA or other service providers of status changes or other pertinent information that may impact services.

HOW TO COMPLETE THE LCP9

PARTICIPANT INFORMATION

114. Enter the Participant's County of Residence
115. Enter the name of the person communication is sent
116. Enter who is sending the communication
117. Select whether you request a response or if it is for information only
118. Enter the Participant's Name:
a. Last; b. First, c. Middle
119. Enter the Participant's SoonerCare ID number (9 digit unique identifier)

A. STATUS CHANGE (If applicable)

Form

120. If communicating a change of status, enter the appropriate date next to the desired change category.

B. ACTION (If applicable)

Form

121. Check the appropriate box and enter the date the action goes into effect. NOTE: The effective date can be different from the date of the status change. Ex: Participant is discharged from the hospital on 03/21/99 but services don't resume until 03/25/99 because the Participant stayed with a family Participant.

C. ADDITIONAL COMMENTS RELATED TO STATUS CHANGE

Form

122. Record the name of the hospital or nursing facility the Participant entered. If admitted to nursing facility as a result of a hospitalization, indicate related diagnosis and anticipated length of stay.
123. If hospitalized, give diagnosis or reason for hospitalization if known. Record any other information that is relative to the status of the Participant.

D. COMMENTS/OTHER

Form

124. Enter any information other than status changes that needs to be related to Living Choice Project Administration or other service provider regarding services.

E. DISTRIBUTION

Form

125. Distribution of LCP9 copy(s) to appropriate agency(s).

SIGNATURES

Form

126. Sign and date the form.
Enter the name of the agency.

ROUTING

1. Copy to transition coordination agency and/or provider(s) for whom communication is intended.
2. Copy from service provider **only in cases with an unresolved grievance or change in the active status of the Participant** to: Living Choice Project Administration, 130 North Greenwood, Suite B, Tulsa, OK 74120.

INSTRUCTIONS for LCP10

Participant Change of Provider

PURPOSE OF FORM

The LCP10 documents that the Living Choice Project Participant has chosen a new service provider and agrees to release case information to that provider. It also documents the service provider's agreement to provide the service(s) listed on this form, as authorized.

HOW TO COMPLETE THE LCP10

PARTICIPANT INFORMATION

127. Enter the Participant's County of Residence
128. Enter the Participant's Name:
 - a. Last; b. First, c. Middle
129. Enter the Participant's Address:
 - a. Street, b. City, c. State, d. Zip
130. Enter the Participant's SoonerCare ID number (9 digit unique identifier)

A. AUTHORIZATION

Form

131. Enter the service provider's name.
132. Have the Participant (or legal agent) sign and date the document.
133. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.

B.

Form

134. Enter the full legal name of the direct service Provider Agency.
135. Enter the title/name of each Living Choice Project and Medicaid State Plan service the identified agency will provide (e.g., Skilled Nursing, Personal Care, Speech Therapy). DO NOT enter non-Medicaid services.
136. Enter the proposed number of units.
137. Specify the type of occurrence for the service.
138. Print the name of the Authorized Representative.
139. Authorized Representative signs and dates the form.

C. TRANSITION COORDINATOR AGREEMENT

140. The Transition Coordinator signs and dates the form.
141. Enter the name of the Transition Coordination Agency.

ROUTING

4. Transition Coordinator forwards copy to provider agency.
 5. Transition Coordinator forwards the original document to Living Choice Project Administration, 130 North Greenwood, Suite B, Tulsa, OK 74120.
 6. Transition Coordinator retains original in the Participant file.
- Living Choice Project Administration**
7. Copies of all received documents are scanned to Participant file.

INSTRUCTIONS for LCP15
Discharge Evaluation

PURPOSE OF FORM

The LCP15 documents the Living Choice Project Participant's reason(s) for discharge (i.e. termination of Living Choice Project Services) and other factors concerning the Participant's status at the time of discharge.

HOW TO COMPLETE THE LCP15

PARTICIPANT INFORMATION

- 142. Enter the Participant's County of Residence
- 143. Enter the Participant's Name:
 - a. Last; b. First, c. Middle
- 144. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
- 145. If the Contact (Contact Name) is someone other than the Participant, enter this person's name
- 146. Enter the Contact telephone number
- 147. Enter the relationship of the Contact to the Participant

A. EVALUATION

- 148. Complete the questionnaire, check appropriate boxes and/or complete the statements. Mark all of the indicators that apply at the time of discharge including specific information as needed.

SIGNATURES

Form

- 149. Transition Coordinator signs and dates the form.

ROUTING

OKHCA

- 4. Transition Coordinator keeps original for the case file and forwards a copy of the form to the Living Choice Project Operations, 130 North Greenwood, Suite B, Tulsa, OK 74120.

Living Choice Project Administration

- 5. Copy of documentation placed in Participant file.

INSTRUCTIONS for LCP21

Eligibility/Claim Resolution

PURPOSE OF FORM

The LCP21 is required for eligibility, prior authorization and/or claim denial issues. The form outlines each step that must be completed before returning the form to the Oklahoma Health Care Authority (OKHCA). Each block must be checked to inform the OKHCA's Claims Resolution Unit that appropriate steps were taken before the OKHCA becomes involved. The OKHCA Claims Resolution Unit will not interface with EDS on behalf of the provider agency until the provider agency has completed the process outlined on the LCP21. One completed form per Participant must be completed and accompanied with the appropriate denial remittance statement when sent to the OKHCA, if applicable.

HOW TO COMPLETE THE AD21

PARTICIPANT INFORMATION

- 150. Enter the Participant's Name:
- 151. Enter the Participant's SoonerCare ID number (9 digit unique identifier)

The following procedures are required for each inquiry.

Step A. ELIGIBILITY

Review the OKHCA eligibility screen.

Form

- 152. Validate that the eligibility screen reflects Title XIX and Living Choice Project.
- 153. If no, check box and fax directly to Living Choice Project Operations Claim Resolution Unit. (If applicable – attach denial remittance statement screen.)
- 154. If yes, proceed to Step B.

Step B. PRIOR AUTHORIZATION

Review the OKHCA eligibility screen form.

Form

- 155. Validate that the prior authorization is on the OKHCA system.
- 156. If no, check box and fax directly to Living Choice Project Operations Claims Resolution Unit. (If applicable, attach copy of denial remittance statement/screen.)
- 157. If yes, proceed to Step C.

Step C. OKHCA RESOLUTION

Contact the OKHCA with any questionable error codes on remittance statement/screen.

Form

- 158. Check the box when completed.
- 159. Enter the name of the person(s) contacted.
- 160. Enter the date of contact.
- 161. Enter the results of the contact.

Step D. OKHCA ASSISTANCE

Submit the LCP21 to the OKHCA – Living Choice Project Operations/Claims Resolution Unit for further assistance. (Fax number 918.XXX.XXXX). **Denial remittance statement or screen printout must accompany the completed LCP21 form.**

- 162. Check the box when completed.
- 163. Enter any additional information.
- 164. Enter your name.
- 165. Enter your title.
- 166. Enter your agency's name.
- 167. Enter the date submitted to the OKHCA.
- 168. Fax to 918.XXX.XXXX.

INSTRUCTIONS for LCP22

Critical Incident Report: Evaluation

PURPOSE OF FORM

The LCP22 notifies the OKHCA or the designee of a critical incident.

HOW TO COMPLETE THE LCP22

PARTICIPANT INFORMATION

- 169. Enter the Participant's County of Residence
- 170. Enter the Participant's Name:
 - a. Last, b. First, c. Middle
- 171. Enter the Participant's SoonerCare ID number
- 172. Enter the Participant's Address:
 - a. Street, b. City, c. State, d. Zip
- 173. Enter the Provider Agency
- 174. Enter Legal Guardian's name, if applicable
- 175. Enter name of Person completing Critical Incident Report Form
- 176. Enter the Participant's diagnosis

A. CRITICAL INCIDENT LEVELS AND EVENTS

Form

- 177. Check the box for the event that best describes the critical incident being reported.

B. DETAILS OF INCIDENT

Form

- 178. Enter the date and approximate time the incident occurred.
- 179. Enter the date the agency became aware of the incident.
- 180. Enter the names of witnesses to the critical incident.
- 181. Enter the location where the critical incident occurred.
- 182. Briefly describe details of the critical incident. If the incident involves an illness or injury, provide documentation of diagnosis. (Attach a separate sheet of paper if needed.)
- 183. Enter Action taken and related outcome(s). Describe what action was taken to assure the Participant's continued health and welfare. Describe the outcome of any follow-up activities. (Attach a separate sheet of paper if needed.)
- 184. Check whether or not the incident resulted in a change in the agency's Continuous Quality Improvement Plan. If yes, state whether or not the change has been implemented along with any related comments.
- 185. Check whether or not agency investigation is required. (See section A, 'Follow Up Requirements,' to determine if investigation is required.) If investigation is required, submit Critical Incident Report: Investigation form (LCP26) to Escalated Issues Department of Living Choice Program Administration within 10 days of submission of Critical Incident Report.
- 17. Check each box to indicate who was notified of the incident. If 'Other' is checked, list name of person notified.

C. SUPERVISORY REVIEW

Form

186. Agency Supervisor signs and dates document.
18. Check whether or not the Critical Incident was a result of failure of the Back Up Plan.

ROUTING

Transition Coordination Agency

19. Submit copy of Critical Incident Report (LCP22) via fax to Escalated Issues Department at Living Choice Project Administration.
20. Original document maintained in agency file.

INSTRUCTIONS for LCP23

Transition Assessment Tool

PURPOSE OF FORM

The LCP23 provides assessment information to support transition planning and initiation/completion of the Transition Planning Tool with the goal of successful transition from nursing facility to community living.

HOW TO COMPLETE THE LCP23

PARTICIPANT INFORMATION

182. Enter the Participant's County of Residence
183. Enter the Participant's Name
 - a. Last,
 - b. First,
 - c. Middle
184. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
185. Enter the Participant's Address
 - a. Street,
 - b. City,
 - c. State
 - d. Zip

PERSONAL DATA

186. Enter the Participant's maiden name or any other names that the Participant has used.
187. Enter the Participant's social security number.
188. Enter the Participant's date of birth.
189. Enter the Participant's place of birth.
190. Check whether the Participant is male or female.
191. Check the Participant's marital status.
192. Check whether the Participant is either his own guardian, or if a family member or other individual has guardianship or Power of Attorney (POA). List name of Legal Guardian/POA.
193. Check whether or not Participant is Medicaid eligible, or does not know eligibility status.
194. Check who receives Participant's social security checks. If 'Other,' list name.
195. Enter name of nursing facility where Participant resides and room number.
196. Enter date Participant was admitted to facility.
197. Enter a contact phone number, either the Resident's personal phone number or the facility phone number.
198. List any other phone numbers provided.
199. List the name and relationship of any family, friends or advocates involved in the Participant's care.
200. List the phone numbers of those individuals listed in step 19.

ASSESSMENT OF 8 DOMAINS FOR TRANSITION PLANNING

201. Review with Participant the questions contained within the remainder of the assessment document. Check all answers that apply. Anecdotal information may be captured in the 'Notes' section.

SIGNATURES

202. Have the Participant or legal representative sign and date the document on the final page.
203. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
204. The Transition Coordinator signs his/her legal signature with date.

ROUTING

Transition Coordination Agency routing of Community Plan

21. Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f),

Transition Assessment Tool (LCP23), Consents and Rights (LCP1), and Service Team Release of Information (LCP5) via fax to Living Choice Project Administration.

22. Original documents are maintained in agency Participant file.

Living Choice Project Administration

9. Copies of all received documents are scanned to Participant file.

INSTRUCTIONS for LCP24

Nursing Facility Transition Planning Tool

PURPOSE OF FORM

The Transition Planning Tool is a dynamic document that reflects the activities required to facilitate the Participant's transition into the community. The Tool is not intended as a static document completed at a scheduled point in the transitioning process, but rather as a fluid document that is modified, revised and updated over time until transition has been accomplished.

HOW TO COMPLETE THE LCP24

PARTICIPANT INFORMATION

- 205. Enter the Participant's Name
 - a. Last, b. First, c. Middle
- 206. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
- 207. Enter the Participant's Address
 - a. Street, b. City, c. State d. Zip

LONG TERM GOAL

- 208. Enter the Participant's Long Term Goal.

Planning Tool

Plan Components – Planning Tool is divided into 8 categories: 1) Self-Determination and Advocacy; 2) Housing; 3) Physical and Mental Health; 4) Daily Living (Personal Assistance & Assistive Technology); 5) Transportation; 6) Social-Faith-Recreation; 7) Employment-Volunteering; and 8) Financial. Additional categories can be added as appropriate based upon Participant need. Complete row for each Plan Component as follows:

- 209. Date Discussed – Enter the initial date planning discussions occur for each category. Add subsequent dates as discussions continue and the plan is revised.
- 210. What needs to be done? – Enter the identified tasks/action steps for each category.
- 211. Who will do it? – Enter the person responsible to complete each task/action step.
- 212. By when? – Enter the date by which each task/action step is to be completed.
- 213. What is date of follow-up? – Enter the date on which follow-up for each task/action step is to be completed.
- 214. Date Completed – Enter the date by when each task/action step is to be completed.

SIGNATURES

- 215. Have the Participant or legal representative sign and date the document on the final page.
- 216. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
- 217. The Transition Coordinator signs his/her legal signature with date.

ROUTING

Transition Coordination Agency

- 23. Original document is maintained in agency Participant file.

INSTRUCTIONS for LCP25 Community Back Up Plan

PURPOSE OF FORM

The LCP25 documents the back up plan to be implemented in the event of a breakdown in essential service delivery. The Back Up Plan addresses all categories of service identified in the transition planning process that could, if interrupted, lead to a critical incident. It is the process used to identify the essential supports necessary to reduce risk of harm to the Participant. The Back Up Plan is reviewed and updated as needed based upon changes in the Participant's situation and/or services.

HOW TO COMPLETE THE LCP25

PARTICIPANT INFORMATION

- 218. Enter the Participant's County of Residence
- 219. Enter the Participant's Name
 - a. Last, b. First, c. Middle
- 220. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
- 221. Enter the Participant's Address
 - a. Street, b. City, c. State d. Zip
- 222. Enter the Participant's Date of Birth (MM/DD/YYYY)

A. REQUIRED DOMAINS

Enter the Participant's Back Up Plan for each Tier. For each specific domain, list the specific risks identified. Include what can be done to reduce the risk and who can provide supports.

- 223. Tier I, Formal Support – Enter the Participant's back up plan for formal supports (provider agencies).
- 224. Tier II, Informal Support – Enter the Participant's back up plan for informal supports (family, friends, neighbors, etc.) to be implemented if no resolution from Tier I, Formal Support back up plan.
- 225. Tier III, 24 Hour Support – Enter how, in the event the Participant does not get resolution from Tier II, Informal Support back up plan, he/she will access the LTCA PICS 800 number and/or OKHCA's PAL after hours 800 number.
- 226. Tier IV, Extreme Emergency – Enter how the Participant will access emergency services if all previous Back Up Tiers fail.

B. ADDITIONAL DOMAINS

- 227. Enter any additional service delivery domains that are essential to the Participant and could, if interrupted, lead to a critical incident.
- 228. Complete each Tier as instructed in Section A.

SIGNATURES

- 229. Have the Participant initial all pages of the Community Back Up Plan except for the final page.
- 230. Enter page number and total number of pages on each page.
- 231. Have the Participant (or legal representative) review the Community Back Up Plan to verify understanding and accuracy. Discuss any questions and/or concerns, and make any necessary changes. Have the Participant check whether or not he/she agrees to the Plan.
- 232. Have the Participant or legal representative sign and date the document on the final page.
- 233. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
- 234. The Transition Coordinator signs his/her legal signature.
- 235. The Transition Coordinator Supervisor signs his/her legal signature.
- 236. Enter the name of the Transition Coordination Agency.

ROUTING

Transition Coordination Agency routing of Community Back Up Plan

24. Initial Community Back Up Plan – Submit copy of the Community Back Up Plan with Initial Community Plan Authorization Request packet via fax to Living Choice Project Administration.
25. Revised Community Back Up Plan – Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f) and revised Community Back Up Plan via fax to Living Choice Project Administration.
26. Original documents are maintained in agency Participant file.
27. Copy of Community Back Up Plan provided to Participant.

INSTRUCTIONS for LCP26

Critical Incident Report: Investigation

PURPOSE OF FORM

The LCP26 notifies the OKHCA or designee of the outcome of investigation of a critical incident. The LCP26 is to be submitted within 10 days following submission of the Critical Incident Report: Evaluation (LCP22).

HOW TO COMPLETE THE LCP26

PARTICIPANT INFORMATION

187. Enter the Participant's County of Residence
188. Enter the Participant's Name:
 - a. Last, b. First, c. Middle
189. Enter the Participant's SoonerCare ID number
190. Enter the Participant's Address:
 - a. Street, b. City, c. State, d. Zip
191. Enter the Provider Agency
192. Enter Legal Guardian's name, if applicable
193. Enter name of Person completing Critical Incident Report Form
194. Enter the Participant's diagnosis

A. CRITICAL INCIDENT

195. Describe in detail the events surrounding the reported incident.

B. EVIDENCE COLLECTED

196. Describe in detail the evidence collected by using: testimonial evidence (interviews with persons familiar with incident); documentary evidence (case notes, provider records, etc.); demonstrative evidence (such as photos, diagrams, etc.); and physical evidence (when relevant).
197. Attach copies of any documents referenced.

C. ASSESSMENT OF EVIDENCE

198. Enter the root cause of the Critical Incident, as determined by assessment of the evidence collected.

D. CONCLUSIONS AND RECOMMENDATIONS

199. Enter all conclusions reached regarding the Critical Incident.
200. Document specific recommendations to resolve current issue.
201. Document specific recommendations to mitigate risks and assure future health and welfare of the Participant.

E. QUALITY IMPROVEMENT IMPLICATIONS

202. Document the impact the Critical Incident and related conclusions and recommendations will have on enhancing the organization's Continuous Quality Improvement System.

F. SUPERVISORY REVIEW

- 203. Agency Supervisor signs and dates document.
- 204. Enter any additional comments as applicable.

G. ROUTING

Transition Coordination Agency

- 1. Submit copy of Critical Incident Investigation Report (LCP26) via fax to Escalated Issues Department at Living Choice Project Administration. Submission required within 10 days following submission of Critical Incident Report: Evaluation (LCP22).
- 2. Original document maintained in agency file.

INSTRUCTIONS for LCP27

Risk Analysis and Planning Tool

PURPOSE OF FORM

The LCP27 form is utilized as a risk management tool in the planning process for reducing and minimizing a Participant's potential risk. Risk is defined as the potential for realization of unwanted, adverse consequences to human life, health, property or the environment. (Oxford English Dictionary)

HOW TO COMPLETE THE LCP27

PARTICIPANT INFORMATION

- 205. Enter the Participant's County of Residence
- 206. Enter the Participant's Name:
 - a. Last, b. First, c. Middle
- 207. Enter the Participant's SoonerCare ID number
- 208. Enter the Participant's Address:
 - a. Street, b. City, c. State, d. Zip
- 209. Enter the Participant's Date of Birth (mm/dd/yyyy)

A. RISK IDENTIFICATION

- 210. Check all significant risk factors identified through the comprehensive assessment process that apply to the Participant. If 'Other,' please list.
- 211. Check whether or not any of the significant risk factors checked are believed to be related to abuse, neglect or exploitation. Include any related comments.

B. RISK EVALUATION

- 212. Significant Risk Factor(s) – In the first block of each row, enter the significant risk factor(s) checked in Section A.
- 213. Severity of Outcome – Check the potential severity for the outcome of each risk factor.
- 214. Frequency of Risk – Check the frequency at which each risk factor could be expected to occur.
- 215. Description of Circumstances – Describe the circumstances which surround each identified risk factor.

C. RISK MITIGATION

- 216. Significant Risk Factor(s) – In the first block of each row, enter the significant risk factor(s) checked in Section A.
- 217. Describe what can be done to prevent or mitigate the identified risk.
- 218. Describe what strengths and/or assets the Participant has that might help to reduce the identified risk.
- 219. Describe any additional supports that might be helpful in reducing the identified risk.
- 220. List who might be helpful in preventing or mitigating the identified risk.
- 221. Check whether or not risk management and monitoring activities have been addressed in the Community Plan. Include any comments.

D. SIGNATURES

222. Have the Participant initial all pages of the Community Back Up Plan except for the final page.
223. Enter page number and total number of pages on each page.
224. Have the Participant (or legal representative) review the Risk Analysis and Planning Tool to verify understanding and accuracy. Discuss any questions and/or concerns, and make any necessary changes. Have the Participant check whether or not he/she agrees to the Plan.
225. Have the Participant or legal representative sign and date the document on the final page.
226. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
227. The Transition Coordinator signs his/her legal signature.

E. ROUTING

Transition Coordination Agency

3. Original document maintained in agency file.

INSTRUCTIONS for LCP30

Transition Funds Request Form

PURPOSE OF FORM

The LCP30 serves as a tool for estimating initial transition costs for prior authorization, and as a final accounting tool for authorization of actual transition expenses.

HOW TO COMPLETE THE LCP30

PARTICIPANT INFORMATION

- 237. Enter the Participant's County of Residence
- 238. Enter the Participant's Name
 - a. Last, b. First, c. Middle
- 239. Enter the Participant's SoonerCare ID number (9 digit unique identifier)
- 240. Enter the Participant's Address
 - a. Street b. City c. State d. Zip

A. PURPOSE OF TRANSITION FUNDS

Explain

- 241. Inform participant that they are eligible for financial assistance in securing housing in the community.
- 242. Inform the participant that the lifetime limit for financial assistance is \$2400 with prior approval, regardless of the number of times that transition may occur.

COMPLETION OF WORKSHEET PAGES (pages 2, 3, 4) IS REQUIRED TO COMPLETE SECTION B OF THE TRANSITION FUNDS REQUEST FORM.

WORKSHEET PAGE INSTRUCTIONS ARE INCLUDED NEXT, FOLLOWED BY INSTRUCTIONS FOR SECTIONS B, C AND D.

REQUISITION FOR HOUSING COSTS (page 2 of worksheet)

SECURITY DEPOSIT

- 243. When appropriate housing has been chosen, check whether the choice of housing is an apartment or an individual property.
- 244. If an apartment is chosen, enter the name of the apartment complex and the contact phone number.
- 245. If an individual property is chosen, enter the name of the property owner and his/her contact phone number.
- 246. Estimated Cost: When submitting the request form for prior authorization, enter the estimated cost of the security deposit as reported by the apartment manager/property owner.
 - a. Transfer this information to Page 1, Section B, Housing Costs – Estimated.
- 247. Actual cost: After housing has been secured, enter the amount actually paid for the security deposit.
 - a. Transfer this information to Page 1, Section B, Housing Costs – Actual.
 - b. Maintain all receipts in the Participant's file.

UTILITY DEPOSIT(S)

- 248. Check to indicate whether or not deposits are required for various utilities (electric, water, gas, phone).
- 249. Enter the name of the contact person for each utility deposit required and that person's contact

phone number.

250. Estimated Cost: When submitting the request form for prior authorization, enter the estimated cost of the security deposit for each utility as reported by the contact person.
- Transfer this information to Page 1, Section B, Housing Costs – Estimated.
251. Actual Cost: After housing has been secured, enter the amount actually paid for each security deposit(s).
- Transfer this information to Page 1, Section B, Housing Costs – Actual.
 - Maintain all receipts in the Participant's file.

OTHER FEES

252. Check to indicate if any additional fees, deposits, etc. are required to procure community housing. Provide a description of the additional costs.
253. Enter the name of the contact person and his/her contact phone number.
254. Estimated Cost: When submitting the request form for prior authorization, enter the estimated cost of the additional fee as reported by the contact person.
- Transfer this information to Page 1, Section B, Housing Costs – Estimated.
255. Actual cost: After housing has been secured, enter the amount actually paid for the additional fee.
- Transfer this information to Page 1, Section B, Housing Costs – Actual.
 - Maintain all receipts in the Participant's file.

REQUISITION FOR TRANSITION AGENCY COSTS (pages 3 & 4 of worksheet)

ESSENTIAL HOUSEHOLD ITEMS

256. Confer with participant to determine household items they may have, household items that can be obtained from family and friends, and items available through any other resources.
257. Complete Essential Household Items list on page 4 of worksheet to reflect items needed that are not available through any other resource. Estimated costs for each item (or group of items) should be estimated to the best of the Transition Coordinator's ability.
258. Estimated Cost: When submitting the request form for prior authorization, total all estimated costs and enter at the bottom of the page (page 4).
259. Sub-total the estimated costs for each category and enter these amounts on Page 3, Essential Household Items.
- Total all estimated costs for Essential Household Items and enter this amount below sub-totals (page 3).
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Estimated.
260. Actual Cost: The Transition Coordinator and Participant both initial the Essential Household Items worksheet on page 4 as each item is purchased/received.
261. Total all actual costs and enter at the bottom of the page (page 4).
262. Subtotal the actual costs for each category and enter these amounts on Page 3, Essential Household Items.
- Total all actual costs for Essential Household Items and enter this amount below subtotals (page 3).
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Actual.
 - Maintain all receipts in the Participant's file.

COSTS TO OBTAIN REQUIRED DOCUMENTS

263. Check any applicable costs necessary for obtaining required documents.
264. Estimated Cost: When submitting the request form for prior authorization, enter the estimated costs anticipated for each document required.
- Enter the total estimated costs for required documents.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Estimated.

265. Actual Cost: When documents have been procured, enter the amount actually paid for each item.
- Enter the total costs for required documents.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Actual.
 - Maintain all receipts in the Participant’s file.

HOME SET-UP COSTS

266. Check any applicable costs necessary for home set-up activities.
267. Estimated Cost: When submitting the request form for prior authorization, enter the estimated costs anticipated for each item anticipated.
- Enter the total estimated costs for home set-up activities.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Estimated.
268. Actual Cost: When set-up activities have been completed, enter the amount actually paid for each.
- Enter the total costs for home set-up activities.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Actual.
 - Maintain all receipts in the Participant’s file.

ONE-TIME HOUSING COSTS

269. Check any applicable one-time costs necessary for preparing the home for habitation.
270. Estimated Cost: When submitting the request form for prior authorization, enter the estimated costs anticipated for each service.
- Enter the total estimated one-time costs for preparing the home for habitation.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Estimated.
271. Actual Cost: When services have been completed, enter the amount actually paid for each.
- Enter the total one-time costs for preparing the home for habitation.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Actual.
 - Maintain all receipts in the Participant’s file.

TRANSPORTATION COSTS

272. Check any applicable costs necessary to meet the Participant’s transportation needs as related to accessing housing.
273. Estimated Cost: When submitting the request form for prior authorization, enter the estimated costs anticipated.
- Enter the total estimated costs for transportation.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Estimated.
274. Actual Cost: When transportation needs have been completed, enter the amount actually paid for each item.
- Enter the total costs for transportation.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Actual.
 - Maintain all receipts in the Participant’s file.

OTHER

275. Check to indicate if any additional costs are anticipated. Provide a description of any additional costs.
276. Estimated Cost: When submitting the request form for prior authorization, enter the estimated costs anticipated for each item.
- Enter the total estimated costs.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Estimated.
277. Actual Cost: When item(s)/service(s) are completed, enter the amount actually paid for each.
- Enter the total costs.
 - Transfer this information to Page 1, Section B, Transition Agency Costs – Actual.
 - Maintain all receipts in the Participant’s file.

B. REQUEST FOR COMMUNITY TRANSITION FUNDS (T2038)

278. Line by line Housing and Agency Costs (estimated and actual, when obtained) should be already entered through completion of worksheet pages 2, 3 and 4.
279. Sum of Housing Costs: Enter the sum of estimated and actual (when obtained) Housing Costs.
280. Sum of Agency Costs: Enter the sum of estimated and actual (when obtained) Agency Costs.
281. Total Estimated Cost: Enter the total estimated costs for both Housing and Agency.
282. Total Actual Cost: Enter the total actual costs (when obtained) for both Housing and Agency.

C. ESTIMATED COSTS – CERTIFICATION AND SIGNATURES

283. Once all estimated costs have been entered, have the Participant (or legal representative) review the Transition Funds Request Form to verify understanding, accuracy and agreement. Discuss any questions and/or concerns, and make any necessary changes.
284. Have the Participant or legal representative sign and date the document.
285. If the Participant signs with a mark, obtain the dated signatures of two witnesses with no interest or conflict of interest in the Participant's affairs.
286. The Transition Coordinator signs his/her legal signature with date, certifying that he/she has consulted with the Participant in the determination of move-in needs and has estimated all related costs to the best of his/her ability.

D. ACTUAL COSTS – FINAL CERTIFICATION AND SIGNATURE

287. The Transition Coordinator Supervisor signs his/her legal signature with date, certifying that he/she has approved the transition items, estimated costs and actual costs outlined in the document.

ROUTING

Submission of Estimated Costs

Transition Coordination Agency routing of Transition Funds Request Form – Estimated Costs

28. Submit packet that consists of copies of the Community Plan Authorization Request Checklist (LCP6f) and Transition Funds Request Form (LCP30, all pages) that reflects all estimated costs via fax to Living Choice Project Administration.
29. Original documents are maintained in agency Participant file.

Living Choice Project Administration

10. Upon review of appropriateness, Authorization of Estimated Transition Funds faxed to the Transition Coordination agency for the requested estimate.
11. Copies of all received documents are scanned to Participant file.

Submission of Actual Costs

Transition Coordination Agency routing of Transition Funds Request Form – Actual Costs

1. Submit copy of Transition Funds Request Form (LCP30, all pages) that reflects all actual costs with Community Plan packet and/or Community Plan Addendum packet via fax to Living Choice Project Administration.
2. Original documents are maintained in agency Participant file.
3. Receipts for expenditures are maintained in agency Participant file.

Submission of Actual Costs - continued

Living Choice Project Administration

1. Authorized Plan (LCP6g) is copied to the Transition Coordination agency.
2. Copies of all received documents are scanned to Participant file.

Transition Coordination/Case Management Agency routing of Authorized Plan

5. Copy of Authorized Plan (LCP6g) provided to Participant.
6. Copy of Authorized Plan (LCP6g) maintained in agency Participant file.

Authorization of Transition Funds

Community Transition Services (T2038)	<p>Service Definition – One Time Transition Expenses: Community transition services (CTS) are a one-time setup expense for Participants transitioning from a nursing facility setting to the Participant's own home or apartment. CTS must be prior authorized in the Participant's Transition Plan and includes security deposits, essential furnishings, setup fees or deposits for utility or service access, including phone, electricity, gas, and water, moving expenses, and services necessary for the Participant's health and safety. Utilities must be in the Participant's name. CTS does not include (l) recreational items, such as television, cable television access, video cassette recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, or computer used primarily as diversion or recreation and does not include monthly rental or mortgage expense, food, or regular utility charges.</p>
	<p>Clinical Review Process – Estimated Transition Costs:</p> <ul style="list-style-type: none">• All requests are reviewed for appropriateness. <p>Possible authorization outcomes:</p> <ul style="list-style-type: none">• Authorization of Estimated Transition Funds (LCP31) faxed to agency.• Not authorized: Request supporting documentation for – or revision of – estimated expenses.
	<p>Clinical Review Process – Actual Transition Costs:</p> <ul style="list-style-type: none">• All requests are reviewed for appropriateness. <p>Possible authorization outcomes:</p> <ul style="list-style-type: none">• Authorization of actual transition funds included on LCP6g and faxed to agency.• Not authorized: Request supporting documentation for expenses incurred.