

## Community Living Options Process Checklist

**Purpose:** To assist in tracking your progress with facilitating a client’s transition, & to coordinate activities

**Acronyms used in this document:**

- ARCH – Adult Resources for Care and Help
- CCT – Colorado Choice Transitions
- CCB – Community Centered Board
- CM – Case Manager
- CTS – Community Transition Services
- EBD – Elderly, Blind, People with Disabilities
- HCBS – Home & Community-Based Services
- ICF – Intensive Care Facility
- ICM – Intensive Case Manager (CCT only)
- TA – Transitions Administrator (HCPF)
- TC – Transition Coordinator
- TCA – Transition Coordination Agency

### I. Referral & Options Counseling

Task		Person Responsible	Date Completed
<input type="checkbox"/>	Receive referral via phone or secure e-mail • Complete top half of <b>Transition Referral Information Form</b>	OC (ARCH or TC)	
<input type="checkbox"/>	Schedule options information meeting with client	OC (ARCH or TC)	
<input type="checkbox"/>	Add referral information to <b>Referral Log</b> • Don't forget to send this log to the TA Monthly! Nora.Brahe@state.co.us	OC (ARCH or TC)	
<input type="checkbox"/>	Meet with client and provide information regarding: <input type="checkbox"/> Community based services <input type="checkbox"/> Housing <input type="checkbox"/> Transition services options (Medicaid CTS/HCBS-EBD or CTS/CCT) <input type="checkbox"/> Transition process and coordinator	OC (ARCH or TC)	
<input type="checkbox"/>	Complete bottom half of <b>Transition Referral Information Form</b> • Request client to sign form	OC (ARCH or TC)	
<input type="checkbox"/>	Send copy of signed <b>Transition Referral Information Form</b> to TA & CMA • For EBD clients: send form to TA • For CCT clients: send to TA & ICM	OC (ARCH or TC)	
<input type="checkbox"/>	If client chooses CTS/CCT explain <b>CCT Informed Consent Form</b> to client • Request client to sign form (CCT Only)	OC (ARCH or TC)	
<input type="checkbox"/>	Obtain copy of doctor’s admitting orders to determine rehab status (NF residents only)	OC (ARCH or TC)	
<input type="checkbox"/>	Provide client with Transition Coordinator Agency (TCA) choices • Refer to TCA chosen by client	OC (ARCH or TC)	
<input type="checkbox"/>	Inform NF or ICF of client’s choice	OC (ARCH or TC)	
<input type="checkbox"/>	Give NF or ICF a copy of signed <b>Transition Referral Information Form</b>	OC (ARCH or TC)	
<input type="checkbox"/>	Submit <b>CCT Informed Consent Form</b> to HCPF CCT Transition Administrator (TA)	OC (ARCH or TC)	

## II. Initial Meeting with Client, Collaboration with Nursing Facility or Intensive Care Facility

Task		Person Responsible	Date Completed
<input type="checkbox"/>	Contact NF or ICF to inform of TC assignment and coordinate meeting with client	TC	
<input type="checkbox"/>	Contact client and schedule first meeting	TC	
<input type="checkbox"/>	Meet with client (& guardian/family if appropriate) Complete the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> Explain <b>Authorization for Release of Information Form</b> &amp; request client signature</li> <li><input type="checkbox"/> Discuss client desires, preferences &amp; concerns</li> <li><input type="checkbox"/> Explain transition process, transition options team, &amp; client's role/responsibilities</li> <li><input type="checkbox"/> Identify Transition Options Team members</li> <li><input type="checkbox"/> Give client copy of <b>Self-Reflection Guide</b> &amp; explain its purpose</li> </ul>	TC	
<input type="checkbox"/>	Consult with NF or ICF to schedule a time & place for the first transition options team meeting	TC	
<input type="checkbox"/>	Refer client to the appropriate case management agency: <ul style="list-style-type: none"> <li><input type="checkbox"/> If case management agency is a CCB - request that a Supports Intensity Scale be scheduled &amp; completed</li> </ul>	TC	
<input type="checkbox"/>	Inform assigned Intensive Case Manager (ICM) or HCBS-EBD CM about the transition options team & first meeting	TC	
<input type="checkbox"/>	Request an initial screening for functional eligibility by phone from ICM or HCBS-EBD CM (NF residents only)	TC	
<input type="checkbox"/>	Conduct initial screening for functional eligibility & inform TC of preliminary finding (NF residents only)	ICM or CM	

## III. Development of Transition Assessment, Risk Mitigation, & Emergency Back-Up

Task		Person Responsible	Date Completed
<input type="checkbox"/>	Plan first Transition Options Team meeting: <ul style="list-style-type: none"> <li><input type="checkbox"/> Contact potential team members - Explain their process &amp; their role</li> <li><input type="checkbox"/> Provide first meeting details (time &amp; location)</li> <li><input type="checkbox"/> Send blank <b>Transition Assessment &amp; Community Needs Inventory</b> to members - Request completion of area of expertise and/or experience with the client</li> <li><input type="checkbox"/> Send <b>Physician Approval Letter</b> to the physician</li> <li><input type="checkbox"/> Request completed assessment &amp; Physician Letter be sent back by a certain date (prior to first meeting)</li> <li><input type="checkbox"/> Give copy of <b>Plan for Community Living Guide</b> to the client &amp; explain purpose</li> </ul>	TC	

Task		Person Responsible	Date Completed
<input type="checkbox"/>	Use the <b>Self-Assessment &amp; Plan for Community Living Guides</b> to facilitate a discussion with client to identify his/her needs, preferences, & desires	TC	
<input type="checkbox"/>	Gather assessment information from each team member (including client's information) & compile onto a master <b>Transition Assessment &amp; Community Needs Inventory</b>	TC	
<input type="checkbox"/>	Facilitate the first Transition Options Team meeting: <ul style="list-style-type: none"> <li><input type="checkbox"/> Review completed <b>Transition Assessment &amp; Community Needs Inventory</b></li> <li><input type="checkbox"/> Review client's completed <b>Self-Assessment &amp; Plan for Community Living Guides</b></li> <li><input type="checkbox"/> Revise assessment as needed during the meeting until the team agrees that it is accurate &amp; complete</li> <li><input type="checkbox"/> Identify risk factors indicated on the <b>Transition Assessment &amp; Community Needs Inventory</b></li> <li><input type="checkbox"/> Develop <b>Risk Mitigation Plans</b> to address each identified risk factor</li> </ul>	TC	
<input type="checkbox"/>	If <b>Risk Mitigation Plans</b> have been developed, obtain client signature on <b>Participant Risk Agreement</b> .	TC	
<input type="checkbox"/>	Begin <b>Emergency Back Up Plan</b> using the <b>Emergency Planning Guide</b> & have client sign when complete	TC	

#### IV. Transition Planning & Service Brokering

Task		Person Responsible	Date Completed
<input type="checkbox"/>	Transfer all identified needs, desires, preferences on the assessment/community inventory forms to the "Assessed Need column" in the <b>Transition Plan</b>	TC	
<input type="checkbox"/>	Facilitate second Transition Options Team meeting: <ul style="list-style-type: none"> <li><input type="checkbox"/> Review the <b>Transition Plan</b> &amp; obtain team approval that it includes all supports/services/preferences indicated on the <b>Transition Assessment, Community Needs Inventory</b> &amp; client's <b>Self-Assessment &amp; Plan for Community Living</b></li> <li><input type="checkbox"/> Use the Service Referral Tool to select appropriate team-member to determine if supports/services are available as stated on the Transition Plan &amp; to broker services</li> </ul>	TC	
<input type="checkbox"/>	Conduct ULTC 100.2 to determine functional eligibility for HCBS & begin service planning & brokering	ICM or CM	

Task		Person Responsible	Date Completed
<input type="checkbox"/>	<p>Facilitate third Transition Options Team</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review Transition Plan to determine if providers have been obtained for all required supports &amp; services</li> <li><input type="checkbox"/> If a provider is not available for a required support or service, develop alternative plan to address that need</li> <li><input type="checkbox"/> Obtain team approval for alternative plan</li> </ul> <p>If team approval cannot be obtained for an alternative plan that will provide for the client's health, welfare &amp; safety, a transition cannot occur through CTS at this time.</p> <p>Request to review situation through the transition decision review process</p>		

#### V. Discharge Planning & Moving Day

Task		Person Responsible	Date Completed
<input type="checkbox"/>	Arrange HCBS services with client and support network	ICM or CM	
<input type="checkbox"/>	Notify CCT TA of discharge date	TC	
<input type="checkbox"/>	Complete Quality of Life Survey and submit to Department ( <b>CCT Only</b> )	ICM	
<input type="checkbox"/>	Issue new certification page and submit to eligibility site	ICM or CM	
<input type="checkbox"/>	Complete CCT or HCBS-EBD PAR <b>For CCT clients</b> , PARs are submitted to Department for review	ICM or CM	
<input type="checkbox"/>	Obtain physician orders, complete facility specific discharge plan, and submit 5615 to eligibility site	NF	
<input type="checkbox"/>	Confirm that "HCBS Rollover" was completed in CBMS by County Eligibility Staff by day of discharge	ICM or CM	
<input type="checkbox"/>	Using the <b>Planning a Successful Move Guide</b> develop a moving plan with client, support network, ICM or CM and nursing facility staff	TC	
<input type="checkbox"/>	Schedule any health and safety assurances that are needed prior to the discharge date	TC	
<input type="checkbox"/>	Purchase, with client, items needed to set up household	TC	
<input type="checkbox"/>	Assist client to set up household	TC	
<input type="checkbox"/>	Facilitate moving plan on day of discharge, ICM or CM is present at facility day of discharge	TC	

**VI. Post Discharge**

Task		Person Responsible	Date Completed
<input type="checkbox"/>	Meet with client at their new home the day of the move; ensure required supports & services are in place and household set up is complete <b>For CCT clients, ICM will also meet with client</b>	TC ICM - (CCT Only)	
<input type="checkbox"/>	Confirm client has <b>Emergency Back Plan</b> & understands its purpose	TC	
<input type="checkbox"/>	Submit final <b>Authorization Request/Cost Report</b> with cancelled checks & receipts for purchases to case manager	TC	
<input type="checkbox"/>	Review <b>Authorization Request/Cost Report</b> <ul style="list-style-type: none"> <li>Confirm client has discharged to community-based residence</li> <li>Notify TC of approval within 10 days</li> </ul>	ICM or CM	
<input type="checkbox"/>	Meet with client in home one week and one month after transition to: <ul style="list-style-type: none"> <li>Ensure required supports and services are in place</li> <li>Ensure <b>Risk Mitigation Plans</b> are being followed</li> <li>Determine if changes to supports, services or <b>Risk Mitigation Plans</b> are needed</li> </ul>	TC	
<input type="checkbox"/>	<b>For CCT only</b> , conduct 48 hour check-in with client and weekly visits in the first month post-discharge. Joint visits with the TC are encouraged.	ICM	
<input type="checkbox"/>	If changes are needed, ICM or CM, TC, client and providers (as needed) meet to establish changes A new <b>Community Transition Participant Risk Agreement</b> must be completed to encompass any changes to a <b>Risk Mitigation Plan</b>	Client, TC or ICM and TC	
<input type="checkbox"/>	Revise the service plan based on changes	ICM or CM	
<input type="checkbox"/>	File new copies of <b>Risk Agreement</b> & <b>Risk Mitigation Plan</b> in client's file	ICM or CM	
<input type="checkbox"/>	Submit CTS claim to Department's fiscal agency for reimbursement/payment	TC	
<input type="checkbox"/>	Submit <b>Community Transition Report</b> to TA via secure e-mail <a href="mailto:CCT@hcpf.state.co.us">CCT@hcpf.state.co.us</a> or fax 303-866-2786	TC	
<input type="checkbox"/>	Close CTS case 30 days after discharge	TC	
<input type="checkbox"/>	List referral transition on the <b>Community Transition Services Monthly Referral Log</b>	TC	
<input type="checkbox"/>	Submit <b>Community Transition Services Monthly Referral Log</b> to TA by the 5 <sup>th</sup> of each month via secure e-mail <a href="mailto:CCT@hcpf.state.co.us">CCT@hcpf.state.co.us</a> or fax 303-866-2786	TCA	