Section Q and Nursing Home Transition Referral Form and Follow Up Form Instructions

For DAIL Aging & Disabilities Resource Connection (ADRC) and Choices for Care/Money Follows the Person (MFP) Programs

User Instructions

VT Aging & Disabilities Resource Connection
VT Department of Disabilities, Aging & Independent Living

October 2013

Form Instructions:

Section Q and Nursing Home Transition Referral Form

Purpose: The Section Q and Nursing Home Transition Referral Form is to be completed for ALL individuals who answer "yes" to the MDS 3.0 Question Q0500B and for all individuals who express a desire to transition out of a nursing home, regardless of whether this request was part of the MDS 3.0 assessment. Such a request may be made outside of a formal MDS assessment and should be referred to the Local Contact Agencies for Options Counseling.

Transmission Instructions:

1. All Section Q referrals must be initiated to the Local Contact Agency **within 7 business days of the MDS 3.0 assessment OR of the individual expressing a desire to discuss the possibility of transitioning—regardless of whether that desire was expressed as a result of the MDS 3.0 assessment process**;
2. Complete form electronically, inputting information as required;
3. Save form with the appropriate file extension, including the following: Section Q Referral Form.NH Name.Date. For example: Section Q Referral Form.Birchwood Terrace.6.5.2013. **Please note, you will want to include any unique identifiers for the client so that when you save, it doesn't overwrite the previous form you saved. For example, if you send several referrals on the same day, you may want to save each with a different number extension so they are saved as unique files.**
4. Email form VIA SECURE EMAIL, as an attachment to the appropriate Local Contact Agency Email address selected. **Please put in subject line: Section Q Referral Form.**
5. **IF NURSING HOME IS UNABLE TO EMAIL SECURELY, PLEASE FAX THE FORM TO THE FAX NUMBER PROVIDED ON THE REFERRAL FORM FOR THAT PARTICULAR LCA.**

Referral Form Organization:

The form is organized into two sections:

1) Referral Contact Information

2) Consumer Referral Information

1) Referral Contact Information (Local Contact Agencies or LCAs):

Referrals for individuals age 60 and over are to be emailed SECURELY or faxed to the Area Agency on Aging in your service area. There is a drop down menu that lists the Area Agency on Aging and the required email address or fax number for the form to be sent. Click on the appropriate AAA in your region, and the email/fax number will be selected.

Referrals for individuals under age 60 are to be emailed SECURELY or faxed to the VT Center for Independent Living. The drop down menu lists the email address or fax number for the form to be sent. Click on the email/fax number to select.

Form Instructions:

2) Consumer Referral Information:

Please note ALL information must be filled in before the referral form is sent. The boxes outlined in red indicate a required field. This information must be completed in order to finish the referral form. Some questions have help text available if you hover your mouse over the answer field. Further guidance or clarification is listed for your review.

Date of Referral: This is the date that the referral is being emailed to the Local Contact Agency. **This field only accepts numbers, and should be input in the format M/D/YYYY (e.g. 5/15/2013).**

Nursing Home Making Referral: The drop down menu includes all nursing homes in Vermont and bordering facilities in New Hampshire and New York. Please click on the appropriate nursing home where the referral is originating.

First Name, Last Name, Email Address, Phone Number, Fax Number Nursing Home Staff Making Referral: Please type in appropriate information. This information will be important for the LCA to conduct follow up with the nursing home, and to serve as the point of contact for any questions.

Other Referral Source if not the Nursing Home: This drop down menu includes other sources that the referral may come from such as a Long Term Care Clinical Coordinator, Ombudsman, or MFP Transition Coordinator who may come into contact with a resident who expresses an interest in learning more about possibility of transitioning out of the nursing home. This information may be learned outside of the required MDS assessment protocols. The LCAs serve as the statewide entities who provide Options Counseling services and should be contacted for follow up to explore this interest.

Please note: this field will not be filled in by the nursing home if it is a referral for Section Q.

Individual's First and Last Names: Please type in the name of the individual/resident for whom the referral is being made.

Individual's Date of Birth: This is a date field accepting only numbers. **Please use the following date format: D/M/YYYY**.

Individual's Town of Residence: This drop down menu includes all Vermont towns. Please select the town in which the individual/resident resides. This should not be the town in which the nursing home is located, UNLESS the individual/resident considers the nursing home his/her legal residence.

Medicaid Number: Please type in the 14-digit Medicaid number for the individual/resident. This field requires numbers only and is limited to 14 characters.

Nursing Home Date of Admission: Please type in the date the individual/resident was admitted into the nursing home. The date format should be M/D/YYYY.

Next of kin/primary point of contact/guardian: This drop down menu asks for you to select the relationship of the person who serves in this capacity for the individual/resident.

Does the individual have a brain injury: Please select yes or no, and is a required field. This is important for the LCAs to know in order to coordinate follow up with our Brain Injury Association partners.

Individual's Primary Disability: This drop down menu contains all of the diagnoses in the MDS 3.0 assessment. Please select the primary disability for the individual.

Form Instructions:

Is the individual on Choices for Care? Please select yes or no.

If the individual is enrolled in Choices for Care, does the individual have a case manager? Please select the appropriate answer, including "no" if the individual/resident does not have a case manager.

Individual's Payer Source: Please select all that apply.

Individual identified a barrier to transitioning back to the community: Please indicate if the person has identified a barrier to transitioning out of the nursing home. This is important for follow up.

If yes, please select type of barrier from the list below: This drop down menu includes various barriers the individual/resident might experience. Please select as many as appropriate or type in the "other" box. This is important information for the Money Follows the Person program.

Special accommodations needed by individual to communicate: This ncludes several types of accommodations an individual/resident might need in order to effectively communicate with the Options Counselor at follow up. Please select all that apply or type in the "other" box. This is very important information in order to adequately meet the individual's needs and to coordinate/plan for follow up.

For Local Contact Agency Use Only: The LCA must indicate the date that the referral was received from the nursing home, and that will be documented as the date in ReferNet. Please note this should NOT be the date that the staff person entered the form into Refer. **This is the date that the LCA RECEIVED the email referral from the nursing home**. It will be important to train staff to remember to input this date field when the email is received. The form may be saved into a file and then data entered into Refer with a referral made to the Options Counselor. Options Counselors are required to contact the resident within 3 business days of the referral being received. Therefore, it is very important to have a paper trail of dates to ensure we are meeting our benchmarks.

Form Instructions:

Section Q and Nursing Home Transition Follow Up Form

Purpose: This form is to be used **by the Local Contact Agencies** to inform the nursing home of the Section Q referral. All Section Q referrals must be followed up by the Options Counselor/Peer Advocate Counselor, and the Follow Up form transmitted to the referring nursing home.

Transmission Instructions:

1) Local Contact Agencies must follow up with all Section Q or Nursing Home Transition Referrals **within 3 business days of the receipt of the Referral Form**. Follow up is initiated with the resident or guardian/primary point of contact.
2) Complete form electronically, inputting information as required AFTER Options Counseling is completed-whether in person, by phone, or other method.
3) Save form with the appropriate file extension, including the following: Section Q Follow Up Form.Local Contact Agency Name.Date.
   For example: Section Q Follow Up Form.CVAA.6.5.2013 **Please note, you will want to include any unique identifiers for the client so that when you save, it doesn't overwrite the previous form you saved. For example, if you send several follow up forms on the same day, you may want to save each with a different number extension so they are saved as unique files.**
4) Email form SECURELY, or if no secure email, via fax, as an attachment to the appropriate Nursing Home Staff Contact Email address or fax number that was included on the Section Q Referral Form for that individual. **Please put in subject line: Section Q Follow Up Form.**

Follow Up Status:

Please note ALL information must be filled in before the follow up form is sent. The boxes outlined in red indicate a required field. This information must be completed in order to finish the follow up form.

Local Contact Agency Conducting Follow Up: Please select your agency from the drop down menu.

Local Contact Agency Informed Nursing Home of Follow Up: Please select "yes" or "no" to indicate whether you informed the nursing home that you would be conducting follow up with the resident upon receipt of the Section Q Referral Form.

Date Options Counseling Provided: Please insert the date that you provided follow up with the individual/resident. If multiple follow ups were conducted, please insert the date of the FIRST follow up or first time you contacted the resident/point of contact. This field requires numbers only in the format: M/D/YYYY.

First Name, Last Name, Phone Number, and Email Address of the Local Contact Agency Staff who Provided Options Counseling: Please type in appropriate information.

Individual's First and Last Names: Please type in the Last and First names of the individual/resident that you provided Options Counseling to. This name should be the name of the Individual/Consumer/Resident, NOT the spouse or guardian or other party.

Form Instructions:

Method of Options Counseling: Please select from the drop down menu or type in "other" field.

Nursing Home Where Individual Resides: Please select the appropriate nursing home from the drop down menu where the individual you provided options counseling to resides.

Outcome of Options Counseling: Please indicate whether the person is continuing with transition planning, or after exploring options, transition is not possible.

If individual continuing with transition planning, next steps include: Please check off all that are appropriate. This is important to inform the nursing home of what the next steps will be and where their assistance/collaboration will be necessary.

If individual explored options for transitioning but transition is not possible, please check all reasons that apply: Please select all appropriate reasons why transitioning is not possible, or type in "other", as learned during the Options Counseling session.

If barriers to transition were encountered that prevent transitioning, please check all that apply below: Please select all appropriate barriers from the list, or type in "other".

Town Individual would like to transition to: Please select from the drop down menu the town where the individual desires to return back to the community. This is important to coordinate referrals and collaboration with other ADRC partner agencies or services and supports.

Other Important Notes: Please use this space to communicate any notes of significance that the nursing home might need to know. This space is limited to 500 characters.

Form Instructions:

Local Contact Agency Referral Process for Money Follows the Person Program (MFP) Program

When a referral is made to the MFP program for a potentially eligible consumer, the following process must be used:

1. **All MFP referrals** MUST be sent via SECURE email to the following email address: ahs.mfp@state.vt.us
2. **Please include in subject line:** Section Q MFP Referral
3. Accompanying documentation with the referral must include:
    a. Options Counseling Intake Form
    b. Options Counseling My Options Plan (if completed)
    c. Section Q/Nursing Home Transition Referral Form (received from the nursing home or other referral source)
    d. Section Q/Nursing Home Transition Follow Up Form (sent to the nursing home)
4. The MFP staff must confirm receipt of referral via email.
5. If there is no secure email, please fax to the following fax number: 802.871.3052