Transition Pre-Screening Form

Oklahoma's Living Choice – MFP

Participant Name: _____ Medicaid ID #: _____

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

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

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

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

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

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

May we contact your family member(s) or friend(s) to meet with you and us to discuss your move into the community? ☐ Yes ☐ No

If yes, please provide name(s) and phone number(s): _____

_____

Do you have a home to move back to? ☐ Yes ☐ No

If yes, please provide the address of the home: _____

If applicable, does anyone live in your home? ☐ Yes ☐ No

If yes, please provide name(s) and relationship to you: _____

_____

(**Pre-Assessment Nurse Note:** Introduce LCP qualified housing options. Tell the participant that while LCP will assist the person to locate qualified housing, the LCP does not cover the cost of rent or utilities and that to participate in LCP, the person must enter 1 of 3 types of qualified housing: 1) A home owned or leased by the individual or the individual's family member; 2) An apartment with an individual lease, with lockable entry door, that includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family have domain control; or 3) A residence, in a community based residential setting, in which no more than 4 unrelated individuals reside).

Which types of qualified residence are you interested in and why? _____

_____

Did you receive services in your home before moving to (name of facility)? ☐ Yes ☐ No

If yes, what services? _____

(**Pre-Assessment Nurse Note:** Review facility records to obtain or confirm this information. The signed informed consent should allow you to obtain these records).

Home and Community Based Services (HCBS) referral to:

☐ Living Choice Demonstration-MFP

Date assessment completed: _____ (mm/dd/yyyy)

Person Refused Program: ☐ Yes ☐ No

(**Pre-Assessment Nurse Note:** If the participant decides to discontinue the interview at any time, ask the person/guardian why they decided not to continue and list reason(s) below).

_____

_____

Pre-Assessment Activity Checklist:

Pre-Assessment Nurse Note: At this point in the interview, administer the Quality of Life Survey, review and obtain signature on the *Consents & Rights, Release of Information and Housing Release of Information* for LCP. Then complete the UCAT I & III and collect any pertinent information required from the Participant's file. Finally, leave MFP Participant Transition Planning Guide with Participant. Send required documents to the Oklahoma Health Care Authority - Long Term Care Waiver Operations: Fax 405-530-7265.

☐ *Quality of Life Survey*
☐ Copy of *LCP Consent & Rights*
☐ Copy of *LCP Release of Information*
☐ Copy of *LCP Housing Release of Information*
☐ Uniform Comprehensive Assessment Tool I & III
☐ Copy of Medication Administration Record (MAR)
☐ Copy of legal documents that cover guardianship (on file at institution)
☐ Copy of documents that cover Medical decision power of attorney (on file at institution)
☐ Distribute MFP Participant Transition Planning Guide (*Currently not available*)
☐ Other (specify) _____

Notes: _____

_____

Pre-Assessment Nurse: _____ Date: _____ (mm/dd/yyyy)

Pre-Assessment Nurse Phone: _____ Email: _____

Date: _____ Time From: _____ Time To: _____ # of Units: _____

Date: _____ Time From: _____ Time To: _____ # of Units: _____

Date: _____ Time From: _____ Time To: _____ # of Units: _____

Total # of Units Requested: _____

Total # of Units Approved: _____

Notes:

_____

_____

_____

_____

○ Congratulations! This member transitioned successfully back into the community on _____. You are authorized to use PA # _____ to bill for _____ units.

○ Unfortunately this member was not able to transition into the community. You are authorized to submit _____ units in an Alternative Funds Invoice.