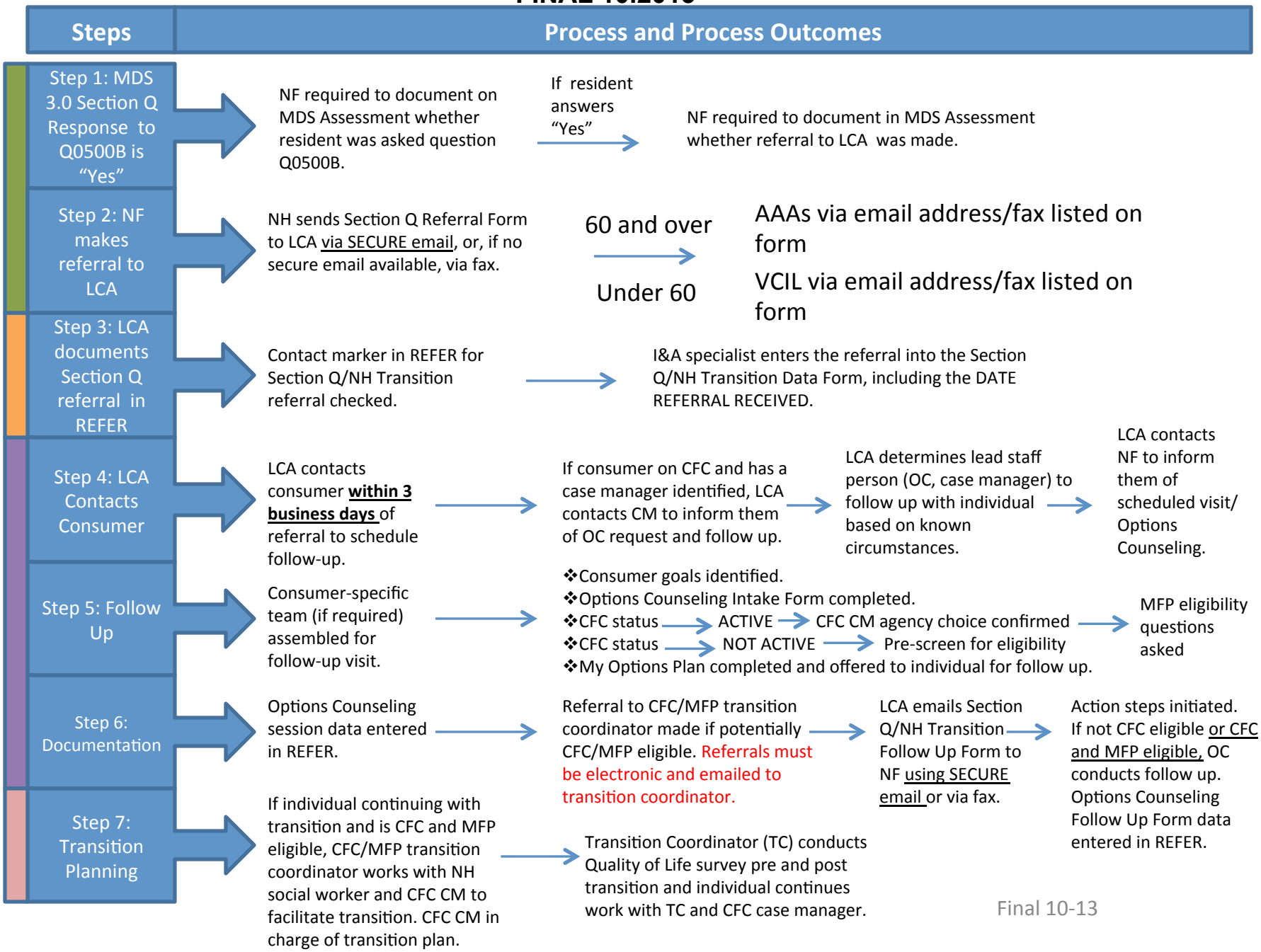
Vermont ADRC-Choices for Care/MFP and Section Q Implementation Strategy
FINAL 10.2013



Important Notes regarding Choices for Care and the Transition Process

- The Options Counselor (OC) should confirm Choices for Care (CFC) status when they follow up with the individual to schedule and coordinate Options Counseling.

- If the individual is **NOT** enrolled in Choices for Care, the Options Counselor should pre-screen for clinical and financial eligibility. If it looks like the individual may be eligible, then the OC can assist the individual with accessing the 202 LTC Choices for Care Long Term Care Medicaid application.

- If the individual **IS** enrolled in CFC but HAS NOT selected a case management agency and the individual selects a case management agency during the course of the Options Counseling process, that information must be shared with the following individuals:
    - Long Term Care Clinical Coordinator
    - Case management agency selected by individual (HHA or AAA)
    - CFC/MFP Transition Coordinator (if eligible for MFP transition funds)

- If the individual is likely CFC/MFP eligible but has not chosen a case management agency, or the individual does not want to choose a case management agency during the course of the Options Counseling process, a referral should be made to the Transition Coordinator who will follow up with the individual at a later point.

- The Transition Coordinator role is to provide outreach and education and enrollment of eligible nursing home residents to the CFC/MFP project and to support the CFC case manager in facilitating the transition process. The Transition Coordinator is not an Options Counselor or Case Manager.

- Should the individual be CFC/MFP eligible and wish to continue with transition planning, the Options Counselor MUST refer that individual to the Transition Coordinator and the chosen CFC case management agency.

- The CFC case manager drives the transition planning process, and the development of the transition plan. The Options Counselor may continue to work with the individual in the nursing home in collaboration with the transition team if desired, but is not required.