



Promoting Wellness and Recovery

John R. Kasich, *Governor*
Tracy J. Plouck, *Director*

**Recovery Requires a Community:
A Program for
Community Transition**

Agenda

- I. Overview of Recovery Requires a Community
- II. Application Exploration
- III. Case Study
- IV. Q&A / Contact Information

What Is Recovery Requires a Community?

- An OhioMHAS budget initiative
- Provide financial assistance to individuals with mental illness to transition and remain stable in community after an institutional stay.
- Works closely with the Ohio Department of Medicaid's HOME Choice program
- Helps to enforce the Olmstead decision, reduce service delivery costs to the state and other systems, and increases community linkage while reducing institutional placements.

Referrals

- Coordination between HOME Choice and Recovery
 - Individuals “Applied, Approved, Not Enrolled”
 - Individuals in immediate danger of returning to a facility
- Coordination between PASRR and Recovery
 - Time limited approvals
 - Denials
- Coordination between providers and Recovery
- Non-HOME Choice participants can still be served!
- Not an exhaustive list

Process: Individuals

- Release of Information
- Application
 - The “but-for” item
 - Due diligence and best practice
 - Incorporates the largest and smallest needs, including housing
- Approval and Funding
- Recertification

Process: System Level

- Real-Time data from individuals
- Aggregate and disseminate with recommendation and funding
- Emphasize creative, evidence based solutions that are cost-effective
- May impact local, state, or federal level

What does this mean for the ...

- ADAMH Board?
- Community Mental Health Center?
- Consumer?

Walking Through The...

- Release of Information
- Application

Three things we look at...
Cost Effective
Leads to Sustainability
Well Articulated and Defended

Please give me anything you think I need to say "yes!"



Release of Information



Name of Provider Assisting with Completion: _____

Name of Person Assisting with Completion: _____

Date _____ Phone # _____

Email _____

Authorization for Release of Information for Recovery Requires a Community

Please return to Recovery@mha.ohio.gov; or fax to 614.488.4504

I, _____, date of birth _____
hereby authorize the release of my personal information to providers or agencies specifically involved in my transition and stabilization in the community, which includes:

- Ohio Department of Mental Health and Addiction Services (OhioMHAS)
- Ohio Department of Medicaid (ODM)
- Ohio County Alcohol, Drug, and Mental Health Boards (ADAMH)
- Providers contracting with OhioMHAS, ODM, and/or ADAMH

I authorize the following information to be released to providers or agencies specifically involved in my transition and stabilization in the community, as well as the evaluation of the program:

- Medicaid information, including claims data
- Community transition/HOME Choice documentation
- Documentation required for Recovery Requires a Community funding application
- Diagnoses and/or treatment for alcohol and/or drug abuse
- AIDS/AIDS Related Complex diagnoses and/or treatment
- HIV test results
- Diagnoses and/or treatment relating to other communicable diseases
- PASRR Information related to my time in an institution



Release of Information

Indicate here any additional exceptions or exclusions, if any, to information released:

This authorization for use/disclosure is for the following purpose:

To assist with my transition from an institutional setting into community.

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. This authorization will remain effective for 365 days, or (fill in date) _____. I understand I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that OhioMHAS has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

Name and Address:

Adam Anderson, 30 E. Broad Street, 36th Floor, Columbus, OH 43215

Signature of Individual/Guardian/Personal Representative:

Date Signed:

Print Name:

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. ORC 5119.27, 5119.28, 5122.31, and/or 42 CFR Part 2 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

V 1.3
4/28/15



Application

Name of Provider: _____

Date: _____

RECOVERY REQUIRES A COMMUNITY: CHECKLIST AND APPLICATION

Introduction & Directions

In order to utilize Recovery Requires a Community funds, a series of steps must be taken to ensure “due diligence.” This is not meant to restrict the amount of money available to the individual, but to ensure that all local resources have been pursued before seeking Recovery Requires a Community funding.

Each section heading is a category of funding for which Recovery Requires a Community will provide assistance, with a section at the end for other, non-categorized needs. Use the checklist to determine what is required, when each step has been completed, by whom, and whether other documentation is required to demonstrate due diligence. At the end of each section, indicate the amount of money requested, utilizing the formulas provided (if applicable). This document will then be submitted to the Recovery Requires a Community program.

Please keep in mind that *you only need to fill out sections that you are requesting funding*. You do not need to fill out the arrears section, for instance, if you are only requesting housing assistance. However, you are required to always send the Basic Information section, as well as the Final Calculation and Attestation.

In addition to this document, if applicable, please affix any other supplemental information that may assist in determining what is needed for the individual.

If there are any questions or concerns, the Recovery Requires a Community office is always happy to answer questions or assist in the process. Please feel free to call 614-466-1064, or email recovery@mha.ohio.gov.



Application

Name of Provider: _____

Date: _____

Basic Information

Participant Name:	Medicaid ID #:
Date of Birth:	Social Security #:
Name of Current Facility:	Address of Current Facility:
Contact at Facility Name:	Contact at Facility Phone #:
HOME Choice Applications Submitted on: ____/____/____	RSS Application Submitted on: ____/____/____
Pre-Transition Case Manager (Name and Phone):	Transition Coordinator (Name and Phone):

Please briefly describe the individual's current health needs, including diagnosis and any significant issues which, at the time of application, are believed to be reasons why Recovery Requires a Community funding is required. **Additionally, please attach any documentation that details a mental health or substance use diagnosis and send with the application:**

Application Completed by:

Date:

Application Reviewed by:

Date:

Application Submitted on:



Application: Housing (Checklist)

Housing Assistance

Note: Recovery Requires a Community is not meant to be a permanent housing subsidy, but is meant to act as a “bridge” until a more suitable option is available.

1. Please rank the following housing types from one to five (1-5) where one (1) means it is most preferred housing & five (5) means it is least preferred. <i>Each number may be used only once.</i>		2. How much support is needed in each of these living environments? <i>Please check only one per line.</i>				
Housing Choices	Rank	Daily	Weekly	Monthly	None	Don't Know
A. Live in a house, apartment, or room by yourself	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Live in a house, apartment, or room with family	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Live in a house, apartment, or room with roommate(s)	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Live in a group setting w/ other clients & have 24/7 staff support on-site	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Live in an assisted living setting	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. What is the address of the house, apartment, or room that the individual is interested in leasing?						

If the individual wants to live in a group setting:

4. Has an application been submitted to the Ohio Department of Mental Health and Addiction Services for the Residential State Supplement Program (RSS)?

Yes (Date Submitted: _____)

No (SEE BELOW)

Note: An Application to RSS must be submitted before approving Recovery Requires a Community Funding.



Application: Housing (Budget)

Budget & Calculation

Line Number	Budget and Calculation	Amount
1	Individual's current monthly gross income (rounded to nearest dollar)	
2	Required amount individual will pay toward rent: Please multiply amount in line 1 by .30 (30%).	
3	If known, please enter the amount of rent here. If unknown, mark "n/a" and use only the Fair Market Rent calculation.	
4	Fair Market Rent: Please refer to this document for current Fair Market Rents. If this number is smaller than #3, please enter it here.	
5	Amount per month of Recovery Requires a Community Resources needed: Please subtract the smaller amount from line 3 or 4 from the amount in line 2.	
6	Annual amount of Recovery Requires a Community Resources needed: Please multiply the amount in line 4 by 12.	
TOTAL	<i>Please enter this amount on the final page of the application:</i>	

Application: Arrears

Arrears

Note: Recovery Requires a Community is not intended to pay for any kind of debts on a long-term basis, and is a last resort. If Recovery Requires a Community can assist by paying a portion of rent or another item so an individual may pay a debt, the program will work to do so. However, the program strongly encourages still filling out the checklist and pursuing the steps, as there may be opportunities to eliminate the debt through other means.

Checklist

1. Explain the nature of the debt:
2. For non-utility related debts, has there been contact to the local legal aid office? (You can find the legal aid office by using this website: <http://www.ohiolegalservices.org/programs>)
 Yes No (SEE BELOW)
In order to qualify for Recovery Requires a Community Funding, you must make contact with a legal aid office. Provide some documentation regarding this contact.

If yes, when was it and what was the response?
3. Have you asked the individual to participate in a Credit Counseling program? (A list of Department of Justice approved Credit Counselors is at: http://www.justice.gov/ust/eo/bapcps/code/CC_Files/CC_Approved_Agencies_HTML/cc_ohio/cc_ohio.htm)
 Yes No (SEE BELOW)
Recovery Requires a Community strongly recommends encouraging individuals to work through a credit counseling program in order to provide assistance in a new approach to finances. These classes may be especially beneficial when an individual is utilizing HOME Choice and an Independent Living Skills Trainer.

If the individual agreed, what program are they utilizing? _____

If the individual declined, what was the reason why? _____
4. If the debt is utility related, have you assisted the individual in applying for any applicable assistance to reduce bills and assist with eliminating debt? (A list of potential options are at: <http://www.puco.ohio.gov/puco/index.cfm/consumer-information/consumer-topics/energy-assistance-programs-help-with-paying-your-utility-bills/>)
 Yes (Please provide documentation) No (SEE BELOW)

In order to qualify for Recovery Requires a Community funding, applications must be made to these programs. Please provide documentation to show that these programs have been applied to and received by the Ohio Development Services Agency.



Application: Arrears (Budget)

Budget & Calculation

1. After all applications have been submitted and assistance received, what is the current remaining debt, and from what source?

Source	Amount (rounded to nearest dollar)
TOTAL:	<i>Please enter this amount on the final page:</i>

Application: SILA

Supplemental Independent Living Assistance

Note: In circumstances where individuals either are no longer eligible for HOME Choice services because they have completed their 365 day stay in community, or were not eligible to utilize HOME Choice for other reasons, Recovery Requires a Community will assist in paying for the same HOME Choice supplemental services *when they are clearly shown to benefit applicants and help them stay in the community.* Additionally, this may cover services that an individual would receive via Home and Community Based Waiver, but a time lag may result in continuity of care.

Checklist

Which services are you requesting for the individual?

<input type="checkbox"/> Independent Living Skills Training	<input type="checkbox"/> Community Support Coaching	<input type="checkbox"/> Social Work/Counseling
<input type="checkbox"/> Nutritional Consultation	<input type="checkbox"/> Homemaker/Personal Care	<input type="checkbox"/> Other: _____



Application: SILA (Budget)

Budget and Calculation

1. Please fill out this table, indicating the amount of hours requested, and the total amount of money needed. If an individual utilized HOME Choice, any number beyond the previous amount of hours utilized will require supporting documentation justifying the increase. For "Social Work/Counseling", indicate why this service is not covered through local community based mental health resources.

Service	Rate	Hours Requested (MAX)	Total \$ Requested
<input type="checkbox"/> Independent Living Skills Training	\$30.00/hr	(144)	
<input type="checkbox"/> Community Support Coaching	\$25.00/hr	(72)	
<input type="checkbox"/> Social Work/Counseling	\$64.12	(36)	
<input type="checkbox"/> Nutritional Consultation	\$52.56	(36)	
	TOTAL	<i>Please enter this amount on the final page:</i>	

Application: Other (Budget)

Budget & Calculation

1. Please fill out this table, indicating the amount of hours requested, and the total amount of money indicated.

Service	Total \$ Requested
TOTAL:	<i>Please enter this amount on the final page:</i>

Application: Final Calculation



Final Calculation and Attestation

Total Request to Recovery Requires a Community

Take the totals from each category and list them below:

Category	Money Requested (\$)
Housing	\$
Arrears	\$
Supplemental Independent Living Assistance	\$
Other	\$
TOTAL:	

Attestation

I, as an individual charged with caring for the above-named client have to the best of my ability determined the needs for the individual, and have been honest in my estimation of the required funding. I will use these resources in a way that is consistent with the intent of the request and with Recovery Requires a Community. Failure to do so may result in the funding being removed, and the denial of my participation in Recovery Requires a Community.

Transition Coordinator

Date

Name of Provider

Pre-Transition Case Manager

Date



Contact Information

Rebecca Civittolo, MSW, LSW

614.466.1064

Recovery@mha.ohio.gov

Rebecca.Civittolo@mha.ohio.gov



Example Decision Matrix for Transition Programs

Scenario:	RSS?	HOME Choice?	Recovery?
Person will be in the facility:			
- Less than 90 days?	Yes	No	Yes
- More than 90 days?	Yes	Yes	Yes
Person will be living:			
- In a Group Home?	Yes	Yes*	Yes
- In their own Apartment?	No	Yes	Yes
- With family?	No	Yes	Yes
Person is diagnosed:			
- With a MH/SUD diagnosis?	Yes	Yes	Yes
- Without a MH/SUD diagnosis?	Yes	Yes	No

Case Study

- Lois, a 55-year-old female
- Dx: Depression, anxiety, diabetes
- Wheelchair bound following surgery
- Lois would like to go home, and the NF social worker believes that Lois could be sustainable in community. SW makes a referral to HOME Choice, and the HC PTCM recognizes that Lois has arrears to the local electric company that must be paid before she can move into a new apartment. Lois' \$2000 in Goods & Services are used on first month's rent and security deposit, but she also needs some start-up groceries and temporary rental assistance while her SSI transitions from institutional status.

Questions?

- Feel free to call Becca at (614) 466-1064 or send an email to Recovery@mha.ohio.gov for more information.
- Additional training is available for local service systems!

Thank you!