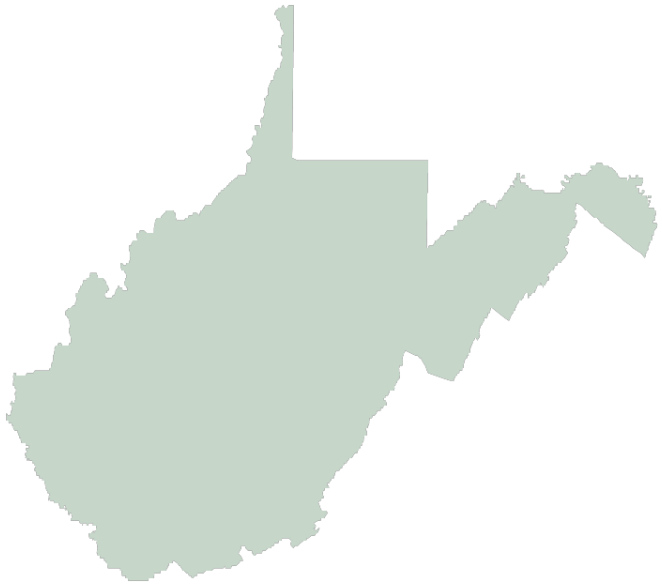
Take Me Home

TMH

Transition Program

We're Helping West Virginians
in long-term care facilities
get back home.

For more information
about Take Me Home,
call our office at **(855) 519-7557**
or visit our website:
TMHWV.org



To make a referral, call the Aging & Disability Resource Center (ADRC) at **(866) 981-2372**.

Or call the Take Me Home office at **(855) 519-7557**.

For more information about the Take Me Home Transition Program, visit our website: **TMHWV.org**

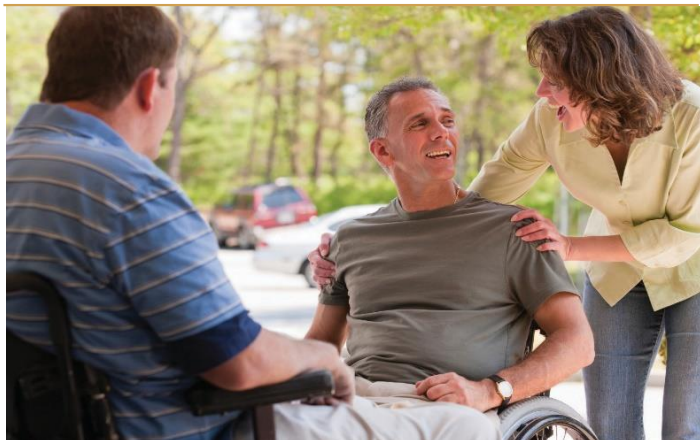
WEST VIRGINIA Department of Health & Human Resources

BUREAU FOR MEDICAL SERVICES

The West Virginia Bureau for Medical Services (BMS) received a Money Follows the Person (MFP) Rebalancing Demonstration Grant in 2011 from the Centers for Medicare and Medicaid Services (CMS).

In West Virginia, the Money Follows the Person (MFP) demonstration program is called Take Me Home, West Virginia. The Take Me Home (TMH) Transition Program provides services and supports to eligible West Virginians wishing to move from long-term care facilities to their own homes in the community.

Individuals wishing to transition to the community often face numerous obstacles including a lack of funds for security and utility deposits, lack of basic household items and furniture, limited community supports, and no one to help develop comprehensive plans to transition home. TMH helps address many of these barriers by providing services and supports including Transition Coordination, Pre-Transition Case Management and Community Transition Services to qualified applicants



Take Me Home TMH Transition Program

The TMH Transition Program provides services to support individuals who are elderly or physically disabled transition from facility-based living to their own homes in the community.

The transition process requires the collaboration and coordination of many “moving parts”, all of which must fall into place on or immediately before transition day; all focused on meeting the individual needs, desires, and goals of the TMH participant. The Transition Coordinator is not only the catalyst for this collaboration but is the glue that holds it all together.

TMH Transition Coordinators work one-on-one with program participants and their Transition Teams to develop person-centered transition plans and facilitate delivery of necessary services to support participants’ transition to the community. Waiver Pre-Transition Case Management is available to qualified TMH participants to ensure that direct-care services are in place day one of their transition home.

Community Transition Service can cover many expenses needed by TMH participants to establish a home in the community.

Allowable Community Transition Service expenses are those necessary to address barriers to a safe and successful transition included in an approved Transition Plan. Waiver Community Transition Services may include:

- Home accessibility adaptation modification
- Home furnishings and essential household items
- Moving expenses
- Rental Security and utility deposits

The MFP Community Transition Service includes:

- Assistive technology
- Specialized medical equipment and supplies
- Initial Food Supply
- Miscellaneous transition support services

Additional MFP demonstration services include:

- Home modification (may be used in conjunction with Waiver Community Transition Services),and
- Personal Emergency Response System (PERS)

To qualify for Waiver Pre-Transition Case Management and Waiver Community Transition Services, TMH participants must:

- Live in a nursing facility, hospital, Institution for Mental Disease (IMD) or a combination of any of the three for at least 60 consecutive days, and;
- Have been determined medically and financially eligible for either the Aged & Disabled Waiver (ADW) or Traumatic Brain Injury Waiver (TBIW) program, and;
- Wish to transition from facility-based living to their own home or apartment in the community, and;
- Have a home or apartment in the community to return to upon leaving the facility that is consistent with the CMS Settings Rule, and;
- Require Waiver transition services to safely and successfully transition to community living, and;
- Can reasonably be expected to transition safely to the community within 180 days of initial date of transition service.