

WEST VIRGINIA OLMSTEAD TRANSITION & DIVERSION PROGRAM
POLICY & APPLICATION INSTRUCTIONS: EFFECTIVE March 1, 2015
Please read the policy and instructions before completing the application.

What is the Olmstead Transition & Diversion Program?

The intent of the Olmstead Transition & Diversion Program is to assist people with disabilities who reside in facility settings to return to or for those who are at risk of facility placement to remain in their home and community. The funding for this Program is very limited and can support approximately 50-70 people per year. Due to the limited funding available, it is critical to allocate funding to those wishing to return home and those at imminent risk of facility placement.

What are facility placements?

Facility placements include nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), state psychiatric facilities (or diversion facilities), rehabilitation facilities, acute care hospitals, or assisted living residences accepting state supplemental funding.

What does imminent risk mean?

The Program may provide diversion support to individuals who are at significant and imminent risk of facility placement. **Imminent risk** means the applicant's mental, physical or medical condition has significantly changed in a way that placement in a facility is being sought or considered. The applicant has the responsibility to provide information explain their imminent risk of facility placement.

Who is eligible for the Program?

The following three (3) eligibility criteria must be met:

1. The applicant must reside in an institutional setting, or be at imminent risk of facility placement.
2. The applicant must have a disability as defined by the Americans with Disabilities Act (ADA), AND
3. The applicant must have been deemed ineligible to participate in the Take Me Home, West Virginia Program.

What does the Program cover?

Allowable goods and services under this Program are those reasonable and necessary to support a transition or diversion from facility placement:

1. **Security deposit** that is required to obtain a lease to occupy a home.
2. **Essential and basic household furnishings** required to occupy a home.
3. **Set-up fees or deposits for utility services** required to occupy a home.
4. **Moving expenses** needed to move to the community.
5. **Home accessibility modifications** are needed to support the individual's disability and increase independence. **Home accessibility modifications** include, but are not limited to, installation of ramps or modifications to bathrooms.

Can a family member or social/civic/religious organization provide the labor to complete home accessibility modifications?

Yes. However, participants are responsible to comply with all local and state regulations, and obtain the appropriate permits, licenses, insurance and bonding.

Is there a maximum amount of funding available under this Program?

Yes. Funding is capped or limited to \$2,500.00 per participant. If the applicant has needs that exceed the cap, other resources must be acquired or leveraged. Also, there is a limit of one approved application per year.

What is not covered by this Program?

The Program will NOT cover the following:

1. Direct or hands-on supportive services.
2. Costs associated with home improvements or repairs that are considered regular maintenance and upkeep of a home. For example: repairing or replacing flooring, cabinets, roofing, siding, decking, drywall, water lines, and/or gas lines).
3. Medications or supplements (prescribed or over-the-counter).
4. Vehicle accessibility modifications, adaptations, or payments.
5. Past due utility bills, rent payments, mortgage payments, credit card bills, or medical bills.
6. Items that have already been purchased, unless there was prior approval.

This is not an all-inclusive list and the review committee reserves the right to determine whether the request meets the intent of the Program.

What are the responsibilities of the applicant?

The applicant must:

1. Complete and submit the application. All applications must include estimates or they will not be processed.
2. Obtain detailed and itemized estimates for all funding that is requested. Estimates for ramps, bathroom modifications, etc. must include detailed estimates and a copy of the contractor's license.
3. Return copies of all final receipts to the Olmstead Office; AND
4. Ensure that the funding is spent only in the manner for which it was approved.

What happens after an application is submitted?

The applicant will receive a letter confirming the application was received and the approximate date the application will be reviewed. A review committee will review the application and determine whether it meets the eligibility criteria for the program. The applicant should expect to receive a letter of approval or denial within two (2) weeks of the approximate review date on the initial letter.

If an application is approved, when will funding be received?

Funding will be processed by the grantee, Community Access, within 20 days of the date of the approval letter. Checks will be made payable to the vendor, supplier, contractor, or entity providing the goods and/or services requested in the application. No checks will be made payable to the applicant.

What if I have questions or need help completing the application?

If you have questions or need help completing the application, please contact Vanessa VanGilder by phone at (304) 558-3287 or (866) 761-4628 or by e-mail at Vanessa.K.VanGilder@wv.gov.

West Virginia Olmstead Transition and Diversion Program
APPLICATION

Date Application Completed		
Applicants First Name		
Applicant's Last Name		
Applicant's Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female

Section 1. Current Living or Residential Setting
Check the setting where the applicant currently is living:
<input type="checkbox"/> Nursing Facility <input type="checkbox"/> ICF/IDD <input type="checkbox"/> In-Patient Psychiatric Facility <input type="checkbox"/> Acute Care Hospital
<input type="checkbox"/> Own Home or Apartment <input type="checkbox"/> With a friend or family <input type="checkbox"/> Assisted Living
<input type="checkbox"/> Rent (permission to make modifications must be obtained from the landlord and submitted with the application)

Facility name (if applicable)	
Facility Admission Date (if applicable)	
Street Address	
City, State and Zip Code	
County	
Telephone Number	

If you reside in your own home, an assisted living facility or with a friend or family, complete Section 2. If you reside in a facility, skip Section 2.

Section 2. Diversion/Imminent Risk
Check the appropriate statement that best describes your situation (one of the following criteria must be met).
<input type="checkbox"/> A PAS-2000 has been completed or initiated for a nursing facility placement
<input type="checkbox"/> My IDT or treatment team has recommended an ICF/MR placement.
<input type="checkbox"/> My physician or treatment team has recommended a psychiatric admission.
<input type="checkbox"/> My physician has recommended a facility placement.

Provide a copy of the PAS-2000, IDT or treatment team minutes, physician orders or other documentation to support the above. If none of the above is applicable, please explain in the space provided below.

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Please answer “yes” or “no” to the following statements to best describe your situation:	
My health or physical status has worsened in the past 3-6 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have been hospitalized in the past 3 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have received care in a facility in the past 6 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I receive in-home supports through Medicaid, Medicare or other paid source.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have informal supports to help me in my home.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am on a waiting list for Medicaid Waiver services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I receive in-home supports but they are not meeting my needs.	<input type="checkbox"/> Yes <input type="checkbox"/> No

For any of the statements you marked yes, please provide information to best describe the situation and how the requested funding will prevent a facility placement:

Section 3. Applicant Disability Status
List the Applicant's Diagnosis(es):

Check if the applicant has one or more of the following conditions:
<input type="checkbox"/> Mental Illness <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Traumatic Brain injury

Dementia-related condition

Check all of the applicant's high risk conditions:

Over the age of 70 Terminal or chronic illness History of substance abuse Multiple emergent care use Catastrophic injury or illness Multiple hospital admissions Other

A diagnosis of mental illness, developmental disability, traumatic brain injury, dementia related condition and/or high risk conditions are not required for eligibility. This information will be used to best provide assistance and referrals for the applicant for additional support.

Section 4. Income and Services Information

Are you a Medicaid member? Yes No Medicaid Number:

Are you a Medicare member? Yes No Medicare Number:

Provide the applicant's total monthly income. \$ _____

Additional income from other household members. \$ _____

Check all that apply toward your monthly income:

Wages Social Security benefits Supplemental Security Disability income State Assistance programs Veterans benefits Worker's Compensation
 Pension or retirement Investment or trust fund Unemployment compensation

Section 5. Home and Community Based Services

Indicate your status with the Take Me Home WV Money Follows the Person program

Program participant Program applicant (awaiting eligibility determination)
 Ineligible I do not know

Indicate your status with the Centers for Independent Living Community Living Services and Supports Program:

Program participant Program applicant (awaiting eligibility determination)
 on waiting list Ineligible I do not know

If you have been determined ineligible for the Take Me Home WV Money Follows the Person program, please include the denial letter with your application.

Section 6. Legal Representative Information

Check the type of representative if you are completing form for this applicant:

Guardian Power of Attorney Conservator Medical Power of Attorney
 Health Care Surrogate Representative Payee Not applicable

Legal representative name:

Relationship to applicant:

Legal representative phone number:

Legal representative address:

Section 7. Funding Request Proposal

Provide the amount of funding that is being requested. The application must include the following to be reviewed:

- ✓ Name and address of the vendor or provider of the goods and/or services.
- ✓ A copy of the contractor's license of any contractors that will be completing the work.
- ✓ Detailed and itemized estimates or actual costs for all funding requested.

Category	Name and Address of Vendor	Amount Requested
Security deposit required to obtain a lease or housing		
Deposit to set up utilities		
Moving expenses		
Essential home furnishings and supplies		
Assistive technology		
Home accessibility modifications		
	Total amount requested	

Has the applicant or anyone in the household applied for funding under this program in the past? Yes No

Describe any goods or services leveraged to assist with this funding request. For example, donated goods or services, volunteer labor, personal funds or family assistance:

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Section 8. Certification and Authorization

My signature indicates the information provided in this application is accurate and complete to the best of my ability, and I have the legal right to act on my own behalf or on behalf of the applicant. My signature authorizes the release of information enclosed in the application to determine eligibility for the program. Applications must be signed by the applicant or a legal representative.
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Signature of the applicant:

Signature of the legal representative:
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Date:

Legal representative address:

Return to:
Vanessa VanGilder, Olmstead Coordinator
Office of Inspector General,
Building 6, Room 817-B, Charleston, WV 25302

Fax to (304) 558-1992 or email to Vanessa.K.VanGilder@wv.gov.

