|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Individual’sName :      | Date of Birth:      | Gender:[ ]  M [ ]  F | Medicaid No.      | Assessment Date:       | Estimated Discharge Date:      |
| Current Facility Name:      | Facility Address:      | Phone Number with Area Code:      |
| Planned Community Address:      | Individual/Individual Representative:       | Phone Number with Area Code:       |
| Relocation Contractor Name      | Relocation Specialist Name:      | Phone Number with Area Code:      |
| MCO Name:      | MCO Service Coordinator Name:       | Phone Number with Area Code:      |
| Was TAS exhausted? ………………………………………………............... [ ] Yes [ ] No [ ] N/A Has the applicant ever received STS (or prior TLC) benefits? … [ ] Yes [ ] No Is the Member moving to a provider owned setting? ..............[ ] Yes [ ] No If yes, Type and Name of setting....       |
| In relocating to the community, I allow the Relocation Specialist to purchase the services/items listed that are basic, essential and necessary for me to establish or re-establish a residence in the community.                                           Signature — Individual/Individual's Representative Date                                         Signature — STS Provider Date                                          Signature – MCO Service Coordinator Date                                          Signature — LIDDA Service Coordinator Date |
| **Deposits**  | **Description/Specification of Service** | **Estimated Cost** |
| Security/Damage Deposit |       | $      |
| Electricity |       | $      |
| Gas |       | $      |
| Water |       | $      |
| Telephone |       | $      |
| Rental |       | $      |
| Other      |       | $      |
| **Total:** |  | $      |
| **Site Preparation** | **Description/Specification of Service** | **Estimated Cost** |
| Moving Expense |       | $      |
| Pest Eradication  |       | $      |
| Allergen Control |       | $      |
| One Time Cleaning |       | $      |
| Other       |       | $      |
| **Total:** |  | $      |
| **Household Items** | **Description/Specification of Items** | **Estimated Cost** |
| Furniture |       | $      |
| Large Appliances |       | $      |
| Small Appliances  |       | $      |
| Housewares |       | $      |
| Cleaning Supplies |       | $      |
| Bath/Toiletries |       | $      |
| Other      |       | $      |
| **Total:** |  | $      |
| **Personal** | **Description/Specification of Items** | **Estimated Cost** |
| Clothing  |       | $      |
| Groceries |       | $      |
| Other       |       | $      |
| **Total:** |  | $      |
| **Delivery Charge:** |  | $      |
| **Final Total:** |  | $      |
| **Comments:** |            |
| I agree that all items have been delivered and are in good working order and condition as indicated by my signature:  STS Provider                               Date            |
| Individual/Individual’s Representative                               Date            |
| MCO Service Coordinator                               Date            |
|  Signature — LIDDA CM/SC                                Date           |

The Supplemental Transition Support Referral form is a method for documentation between the Managed Care Organization (MCO) and Relocation Contractors of items identified for purchase for this benefit. It is the responsibility of the Relocation Contractor to complete the form and obtain agreement from the MCO Service Coordinator and LIDDA CM/SC if applicable for the purchase of STS items. Both the MCO and relocation agency must retain a copy of the STS form for future audit/reporting. STS Form, Receipts and STS Checklist must be submitted to MCO no more than 10 business days following relocation. (If you encounter any outliers exceeding this timeframe due to obtaining signatures, etc., submit documents as soon as all required information obtained.)

**Name:** Member’s Name

**Date of Birth**: self explanatory

**Gender:** self explanatory

**Medicaid ID**: assigned Medicaid identification

**Assessment Date**: Initial date the Relocation Contractor assessed member for STS.

**Estimated Discharge Date**: This is the date the member/LAR would like to transition to community. This is a projected date and may or may not be the actual date of relocation.

**Current Facility Name**: Name of current nursing facility where individual resides at the time of assessment.

**Facility Address**: Actual street address including street number city, state, and zip code for current nursing facility.

**Phone Number with Area Code**: Main phone number to nursing facility.

**Planned Community Address**: Document the street number, city, state, and zip code. If the relocation address is an ALF/AFC or apartment complex, the name of the facility should be identified at the beginning of this section followed by full address.

**Individual/Individual Representative:** Name of the individual relocating or the person identified by the individual as a designated representative or Legally Authorized Representative (LAR).

**Phone Number with Area Code**: Document the phone number at the identified relocation site or if a designated representative or Legally Authorized Representative (LAR).

**Relocation Contractor Name**: Name of the contracted relocation agency.

**Relocation Specialist Name**: Name of the assigned relocation contractor assigned to assess for STS.

**Relocation Number Code**: Direct phone number for the STS assessor.

**MCO Name**: Identify managed care organization.

**MCO Service Coordinator**: Name of the assigned service coordinator employed by the manged care organization.

**Was TAS exhausted?**: Applicable to TAS items only. If TAS items have been purchased using TAS benefit and there are no dollars available response is “**Yes**”. “**No**” applies only when the items requested are not a covered TAS item. “**N/A**” applies when there are no TAS items purchased for relocation.

**Has the applicant ever received STS (prior TLC) benefits?**: Applicable only to items covered using STS. If answer is “**Yes**”, no benefits are available to the individual. If “**No**”, individual may qualify up to $2500.00 maxim benefit

**Is the Member moving to a provider owned setting?:** Must always be answered for completed form. Answered “**Yes**” if individual is relocation to an Adult Foster care Home (AFC), Assisted Living (AL), or personal care home. If none of these options are chosen answer is always “**No**”.

**In relocating to the community, I allow the Relocation Specialist to purchase the services/items listed that are basic, essential and necessary for me to establish or re-establish a residence in the community:** Must be signed and dated by either the Individual/Designated Representative/LAR, but must include the STS provider/or Relocation Specialist, the MCO Service Coordinator signature and LIDDA Service Coordinator (if applicable). A verbal acceptance from the MCO Service Coordinator or the Designated Representative/LAR in lieu of a written signature is acceptable in this space. The date of the Designated Representative/LAR and/or MCO SC agreement must be designated in the area for the date. Verbal approval is required for additions or deletions of items. A new verbal approval must be obtained with changes in purchase items.

**Sections for**:

|  |  |  |
| --- | --- | --- |
| **Deposits**  | **Description/Specification of Service** | **Estimated Cost** |

Must include the type of deposit as designated in area for “**Deposits**”, “**Description/Specification of Service”** name of the agency/organization who will be paid and purpose such as “**Texas Gas Company for gas service**”. “**N/A**” or a line may be drawn in the space designated for this section if item is not purchased. “**Estimated Cost”** may be an estimation of item or actual dollar amount of the deposit if known. **“Other”** is used for any deposit allowable and that may not be identified on form. The **“Total”** amount must be tallied where appropriate. If no items are purchased from section, document **“N/A”** in the description column and $0.00 in the estimated cost and “**Total**” section. More than one vendor may be used to make purchases from this section.

|  |  |  |
| --- | --- | --- |
| **Site Preparation** | **Description/Specification of Service** | **Estimated Cost** |

Must include the name of the business/agency who will be responsible for items in this section. A “**N/A**” or a line may be drawn in the space designated for “**Description/Specification of Items**” if an item is not being purchased. If an item is purchased include the name of the agency/business and a brief description of the purchase. **Example:** “**ABC Pest Control for the eradication of roaches and other insects**” The “**Estimated Cost**” must be designated for each item purchased in this section. The “**Total**” purchase dollars estimated for this section must be documented in the “**Tota**l” section. If no item purchased from this section, a “**$0.00**” is designated in the area designated “**Total**”. More than one vendor may be used to make purchases from this section.

|  |  |  |
| --- | --- | --- |
| **Household Items** | **Description/Specification of Items** | **Estimated Cost** |

Must include the type of “**Household Item**” as designated in this area of the form. For items purchased, a specific description must be included in the section designated “**Description/Specification of Service”** name of the agency/organization who will be paid and a description of the item being purchased such as **“All Rite Furniture Company:** **Brown Sit Rite Couch**”. “**N/A**” or a line may be drawn in the space designated for this section if item is not purchased. “**Estimated Cost”** may be estimation of item or actual dollar amount of the deposit if known. **“Other”** is used for any item allowable under benefit and that may not already specified on the STS form. The **“Total”** amount must be tallied where appropriate. If no items are purchased from section, document **“N/A”** in the description column and $0.00 in the estimated cost and “**Total**” section. More than one vendor may be used to make purchases from this section.

|  |  |  |
| --- | --- | --- |
| **Personal** | **Description/Specification of Items** | **Estimated Cost** |

Must include the type of “**Personal Item**” as designated in this area of the form. For items purchased, a specific description must be included in the section designated “**Description/Specification of Service”** name of the agency/organization who will be paid and a description of the item being purchased such as **“Kohl’s Dept. Store: one pair wrangler jeans, one jersey jacket, 3 pair Fruit of the Loom briefs, 2 pair white socks**”. “**N/A**” or a line may be drawn in the space designated for this section if item is not purchased. “**Estimated Cost”** may be estimation of item or actual dollar amount of the deposit if known. **“Other”** is used for any item allowable under benefit and that may not already specified on the STS form. The **“Total”** amount must be tallied where appropriate. If no items are purchased from section, document **“N/A”** in the description column and $0.00 in the estimated cost and “**Total**” section. More than one vendor may be used to make purchases from this section.

**Delivery Charge**: Identify “Total” set up fee (s) or delivery charge (s) for items purchased.

**Final Total**: Identify grand total for all STS items identified on the STS form for purchase.

**Comments**:

**Signature**: Signatures and the confirmation date must be documented for the STS provider/Relocation Specialist, Individual/Designated Representative/ or LAR, the MCO Service Coordinator and LIDDA Service Coordinator (if applicable) to confirm all items were received in good condition and good working order. The STS provider/relocation Specialist must review the form with the individual/Designated Representative or the LAR on the date of relocation to the community and must sign, obtain the signatures and dates from the Individual/Designated Representative or LAR, MCO SC and LIDDA SC (if applicable) to document receipt of all items in good working order and good condition on the day of relocation. The Relocation Specialist must provide the LIDDA SC with a copy of the completed STS form that has been signed by the Relocation Specialist, the MCO SC and LIDDA SC. The STS Checklist or Relocation Contractor equivalent checklist must accompany the final STS form on the day of SOC. A copy of the STS form along with purchased item receipts must be provided following move out.