

CONTRIBUTING ORGANIZATIONS

Access Center for Independent Living
Achievement Centers for Children
Advocacy and Protective Services (APSI)
AARP
American Association of Service
Coordinators
Amerigroup
Assistive Technology of Ohio (AT Ohio)
Autism Society of Ohio
Bittersweet Inc.
Brain Injury Association of Ohio
Brethren Care Village
Buckeye Community Health Plan
Cerebral Palsy Association of Ohio
Coalition on Homelessness and Housing
in Ohio
Creative Housing Corporation
Definitive Home Health Care
Delaware Creative Housing
Easter Seals of Ohio
Episcopal Retirement Homes, Inc.
Family Services Council of Ohio
Good Samaritan Hospital
Greater Dayton TRA
Heritage Day Health Centers
Housing and Urban Development (HUD)
Heritage Health Care Services
Housing Leadership Institute
Legislative Services Commission
Linking Employment, Abilities and
Potential (LEAP)
Long Term Care (LTC) Ombudsman
Program
Mercy Saint John's Center
Miami Valley In-Ovations, Inc.
National Alliance on Mental Illness
of Ohio
National Church Residences
Ohio Academy of Nursing Homes
Ohio Advocates
Ohio Alliance for Direct Support
Professionals
Ohio Assisted Living Association
Ohio Association Adult Caregivers
Ohio Association of County Behavioral
Health Authorities
Ohio Association of County Boards of DD
Ohio Association of Superintendents of
County Boards of DD
Ohio Board of Regents
Ohio Association on Area Agencies
on Aging
Ohio Capitol Corporation for Housing
Ohio Centers for Independent Living
- CILS
Ohio Conference of Community
Development Organizations
Ohio Council for Home Care
Ohio Department of Aging
Ohio Department of Alcohol and Drug
Addiction Services
Ohio Department of Development
Ohio Department of Mental Health
Ohio Department of Developmental
Disabilities
Ohio Department of Transportation
Ohio Dietetic Association
Ohio Health Care Association
Ohio Hospice & Palliative Care
Organization
Ohio Hospital Association
Ohio Housing Authority Conference
Ohio Housing Authority Finance
Ohio Jewish Communities
Ohio Job and Family Services Directors
Association
Ohio Legal Rights Services
Ohio Office of Budget and Management
Ohio Olmstead Task Force
Ohio PATHS
Ohio Provider Resource Association
Ohio State University-Public Policy,
Assistive Technology
Ohio United Way
Rehabilitation Service Commission
RHC, Inc.
Sarah Care Adult Day Services
Service Employees International Union
- SEIU 1199
The Ability Center
The Advocate of Not-For-Profit Services
for Ohioans (AOPHA)
The Success Group
Wright State University - School of
Medicine

And, all consumers and families who
have participated

Minimum Data Set 3.0 Section Q (Referral to Community Living)

The Minimum Data Set (MDS) is a powerful tool for implementing standardized assessment and for facilitating care management in nursing facilities (NFs). The newest version, which became effective October 1, 2010, is designed to improve the reliability, accuracy and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings. These improvements have profound implications for NF care and public policy.

MDS 3.0 includes an expanded "Section Q," which is designed to collect information regarding a person's potential transition to a community setting. As part of the MDS 3.0 implementation, the Ohio Department of Job and Family Services (ODJFS) is required to designate "Local Contact Agencies" (LCAs) and provide training on Section Q implementation. NFs are required to send Section Q information to a designated LCA. The LCA is expected to provide an information referral service, transition planning or both.

ODJFS received approval from the Centers for Medicare and Medicaid Services (CMS) to implement MDS 3.0 Section Q with a cross-disability approach for information and referral that matches the approach used for HOME Choice transition coordination. ODJFS will serve as a clearinghouse for Section Q information, making referrals to local entities for follow-up and possible referral for transition coordination within the HOME Choice transition program. Doing so will create a statewide, cross-disability approach to information, referral and transition coordination and will help the state better understand the needs of those in nursing facilities who want to move back into home and community settings.

Stay tuned for more information in later editions of this newsletter or visit our Web site at <http://jfs.ohio.gov/OHP/consumers/homechoice.stm>.

HOME Choice Consumer Advisory Council Kicks Off

In May and June the Ohio Olmstead Task Force and the Ohio Developmental Disabilities Council invited applications from elderly Ohioans and Ohioans under age 60 with disabilities who would be interested in serving on the new **HOME Choice Consumer Advisory Council**. As Ohio embarks on system reform to balance the long-term services and supports delivery system, including both Medicaid and non-Medicaid, input and support from those who are directly impacted by the system is important and necessary.

The HOME Choice Consumer Advisory Council represents those:

- o With intellectual disabilities
- o With developmental disabilities
- o With physical disabilities
- o With mental illness
- o With traumatic brain injury
- o Who are elderly

- o Who are in active recovery from alcohol and/or other drug addiction/abuse
- o Who are family members and/or legal representatives of a child with a disability.

The council held its kick-off event on October 27-28 at Deer Creek State Park. State agencies and advocacy organizations presented information to council members and invited them to participate in stakeholder groups.

For more information about the council, please contact Shelley Papenfuse or Mary Butler of the Ohio Olmstead Task Force (<http://ohioolmstead.org/contact.php>).

HOME Choice Wins Award

On November 1, the HOME Choice Program received the **Community Capacity Building Award** from the Brain Injury Association of Ohio (BIAOH). HOME Choice received the award not only for its work to help institutionalized people move back into community settings, but for its efforts to increase the availability of suitable housing for those participating in the program. The award was presented at the BIAO's Annual Convention, which this year was titled "Building Community: Recognition, Response, Resilience."

Ohio Participates in National Interagency Autism Coordinating Services Workshop

The federal Interagency Autism Coordinating Council (IACC) Services Committee hosted a workshop on November 8 in Rockville, Maryland, featuring several presentations from various state and national experts on self-direction, assessment, seclusion and restraint, workforce, housing, peer supports, and integration.

Presenters included John Martin, director of the Ohio Department of Developmental Disabilities, and Erika Robbins, HOME Choice project director for the Ohio Department of Job and Family Services. In addition, the workshop highlighted **Ohio's Interagency Workgroup on Autism**.

More information is available at <http://iacc.hhs.gov/events/>.

HOME Choice Success Stories

This issue *HOME Choice Bulletin* features three success stories written by CareStar case managers. CareStar, the case management agency for the Ohio Home Care (OHC) program, manages approximately 13,000 OHC waiver consumers in Ohio. Of that number, more than 400 consumers are enrolled in HOME Choice in combined waiver/non-waiver programs.

CareStar has provided case management services since 1988. Robert Jones, CareStar's HOME Choice manager, reports that CareStar is proud of its role in Ohio's HOME Choice program.

John Ashwood – Overcoming Obstacles

By Terri Shaffner, CareStar Case Manager

John Ashwood has had many struggles and challenges in his life, but with the CareStar Team and the Home Choice Program, he has overcome them. This is John Ashwood's story.

John worked his entire adult life in restaurants, laundry facilities and as a security guard. In 2003, he became unemployed and, eventually, found himself homeless. He was dependent on hot meal programs through various organizations to survive. He finally found a place to stay when his previous landlord passed away and the apartment building he had owned went into foreclosure. John still had the key to his old apartment, so he slept there with no heat or utilities.



CareStar Case Manager Terri Shaffner and HOME Choice consumer John Ashwood in John's new apartment.

John was able to work temporary jobs on and off, but had no work during the month of December 2003. He had not been feeling well, so his friends asked him to go to Metro Hospital. His feet were numb because they had become frozen, and there was no longer circulation in them. Both of his legs had to be amputated.

After his hospital stay, John tried unsuccessfully to live on his own. He then went to a nursing home for physical therapy and learned to use prosthetic legs. He persevered and made progress but still primarily used a wheelchair. He also missed living on his own. Then he learned about the HOME Choice Program and was referred to me for case management help.

Shortly afterward, in October 2009, John moved into his own apartment. He has continued his physical therapy and other HOME Choice services. Eventually, he learned to walk with the help of a walker and then with two canes. As you can see from the photo, over the last year John has learned to stand with one cane. His goal is to walk with one cane by the spring of 2011.

John has shown tremendous resilience. With the extra support network that the CareStar Team and the HOME Choice program have provided, he has been able to overcome his adversities and adapt successfully to living in the community.

Due to this collective effort, John's life has completely changed. He attends most of the apartment complex activities, he has made many new friends, and he goes on trips to the library, the park and an amputee support group. He loves to eat out and is able to continue his favorite hobby of ceramics. He no longer needs in-home physical therapy but does his physical therapy exercises on his own, in his own home and at his own convenience.

John is no longer afraid to go out. Now that he is mobile, he is so active that he has to keep a calendar of all his social activities. It hangs on the wall of his home and features a quote that captures the essence of his new life: "Imagine, Dream, Grow, Create, Become, Growth Contains Happiness." John has proven this to be true and is an inspiration to everyone who knows him.

With CareStar, the HOME Choice Program and his unrelenting strength, John has survived, overcome difficulties and is now an independent and successful contributor to society. There is no doubt that John will reach his goal of walking with one cane by spring!

Karen Palacios Meets Goal of Moving Home on Her Birthday

By Michelle Mitchell, CareStar Case Manager

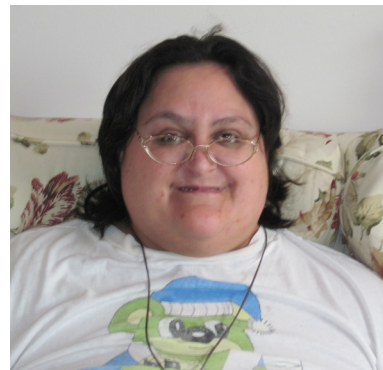
I am a team-based case manager with CareStar and have been employed by CareStar for four years. I have always had a strong desire to work with people, which led me to where I am now. Approximately a year ago, I had the opportunity to become involved in the Money Follows the Person (MFP)/ HOME Choice Program. During this time, I have assisted many consumers to transition from nursing facilities back to their home environment.

Karen Palacios is one of those. I met with Karen on June 14, 2010, at the nursing facility where she resided. The purpose of my visit was to gather information to complete her initial assessment. She had spent the past several years in long-term placement. Karen was motivated to return to the community and was a strong advocate to make this happen. She had set a goal to be discharged from the nursing facility by her next birthday, August 5.

I spoke with Karen regarding processes that needed to occur to make this a reality, such as securing housing, locating a physician, educating herself about diabetes management, accessing medical equipment and locating a home care agency.

On July 28, 2010, Karen's HOME Choice Transitions Coordinator advised me that Karen's apartment had passed inspection and was ready for her to move in. We scheduled a discharge-planning visit for August 8, 2010. In addition to Karen, the meeting included the nursing facility social worker, transition coordinators and me. During the discharge-planning visit, each participant was aware of the role each would take to allow discharge to occur on the following day.

All was moving smoothly until a snag occurred. Karen still did not have a community-based physician. With teamwork and communication, however, this issue was quickly resolved!



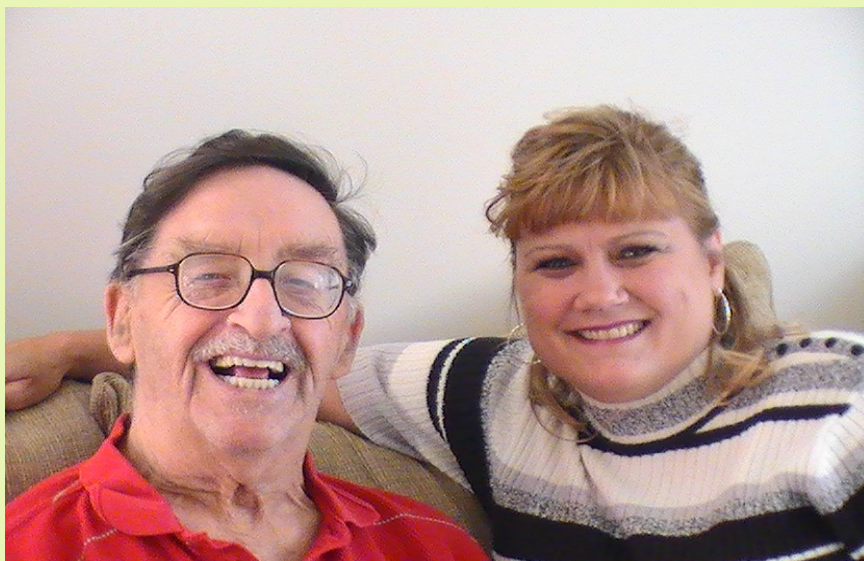
Karen Palacios moved on her birthday.

I am happy to report Karen was discharged from the nursing facility on August 5, 2010, which was the goal date she had set for herself. Karen and her home health aide had all her boxes unpacked and organized within three days of moving into her apartment. She enjoys visiting friends and is an avid crafter, which she looks forward to pursuing again. Most importantly, she cherishes having her own space. According to Karen, she now has complete control over her life, and "independence is pure freedom."

During my years employed in long-term care, I have seen many residents who would be able to function in their own home environment if just given the chance. Thanks to the HOME Choice program, many now have this opportunity. I am honored to be a part of CareStar's HOME Choice team, which helps this dream become a reality for many.

Ralph Wilt's Transition Increases His Confidence

By Penny Sellers, CareStar HOME Choice Specialist.



Ralph Wilt and his CareStar Case Manager Penny Sellers

My name is Penny Sellers, and I have been a HOME Choice Specialist with CareStar for the HOME Choice program for one year. This position has created many new challenges and opportunities for me. I have met with consumers throughout the state of Ohio who are enrolled in the HOME Choice program. Many consumers are genuinely thankful for the HOME Choice program, and some have stated that if the HOME Choice program did not exist, they would have been unable to transition out of the nursing facility because of financial issues, lack of self-confidence, fear of returning to the community and inability to secure housing.

The transition to community living requires a team effort to ensure a positive transition for the consumer. Coordinated planning and follow-up are necessary to create a safe discharge and successful community living experience.

Of all the success stories I have experienced, Ralph Wilt stands out to me. When I first met him at his discharge meeting in the nursing facility, he did not talk much and would not look at me. Several people at the nursing facility did not believe he could successfully transition. Some thought he would return to the nursing facility within a month.

When Ralph was discharged, there were challenges, but everyone involved worked as a team and did a great job. With the collaboration of the HOME Choice specialist and the transition coordinator, and in partnership with the community support coach, independent living skills trainer, social workers, nutritional counselors, nurses, home health aides, service animal providers and communication aide providers, he has successfully moved back into the community.

Ralph lives in an apartment in Columbus, which has several advantages for him, including the fact that his independent living skills training provider is on-site. I spoke with the apartment service coordinator the day I visited him, and she shared that Ralph also benefits from the apartment building's homemaker services, adult day care, transportation and service coordination.

"Ralph has come a long way," she said. "He is allowing people in his apartment to cut his hair and is getting more involved." Even the transition coordinator stated: "Ralph has grown so much in his confidence. He smiles and talks to everyone and has improved in his ability to take care of himself. He has a wonderful sense of humor and is always cracking jokes. When I first met him, he would hardly talk or get out of his bed. He was afraid to move."

I also met the independent living skills trainer, Francie Hughlock, who has worked with Ralph since the beginning of his transition. She, along with others, has worked closely with Ralph and is credited for much of his success. She taught him how to grocery shop, clean his apartment, do his laundry, prepare his own meals and much more.

Ralph also worked with a community support coach. With the help of the transition coordinator, independent living skills trainer, registered nurse and me, Ralph keeps moving forward in a positive and productive way. I communicate with him monthly to ensure all of his HOME Choice non-waiver services are being provided. I also make intermittent visits with him throughout the year.

During our last visit, Ralph and I talked about when he first moved into his apartment and wanted to go to the grocery store. He decided to climb over some bushes between his apartment building and the grocery store – but fell and got scraped up pretty good. Ralph laughed when he said, “I guess I learned my lesson – I can’t crawl over bushes anymore.”

Ralph has shown great progress since transitioning into the community. I believe when Ralph concludes his 365-day demonstration period, he will be able live a successful and independent life.

News of Interest to Transition Coordinators, Case Managers and SSAs

Best Practices: Ombudsmen Share Transition Coordinator Lessons

The *HOME Choice Bulletin* thanks the AAA-7 Regional Ombudsman Program for providing the following best practices gained from staff members’ and volunteers’ experiences as HOME Choice Transition Coordinators.

1. If a resident’s family is able to assist with the purchase of goods and services, setting up in the new home, and/or with the actual move, the process is much smoother for the resident, as well as the transition coordinator. **Family support and assistance are difficult to replicate.**
2. If a resident has lived in a nursing home for a long period of time, he or she may have slowly become “institutionalized” and may need psychological support to transition successfully. **This may mean helping the resident to secure needed psychological support and counseling.**
3. **Early discharge planning meetings at the nursing home** with the resident, case manager, transition coordinator, the home’s social worker and director of nursing, rehabilitation staff, family, and others are necessary for a successful transition. **Everyone needs to be on the same page.**
4. Residents receive \$2,000 in HOME Choice funds to purchase goods and services. For many, \$2,000 is not enough to pay for their first month’s rent and deposit, utility deposits, transportation, household goods, furniture, food, etc. Transition coordinators must identify other ways to obtain the needed goods and services for the client, such as through food banks, donations, “going-away showers,” etc. They also should utilize their negotiation skills to advocate for lower rent and deposits.
5. Residents who move before in-home services are set up are less likely to have successful transitions. **Residents have the right to leave the nursing home against medical advice, but transition coordinators and case managers have a responsibility to educate them about the risks and consequences of doing so. They should have these conversations early in the transition process.**
6. **To make for a smoother, safer transition, it’s better for residents to be discharged from nursing homes early in the week, as opposed to a Thursday or Friday.** This allows kinks to be worked out before the weekend, when most agencies are closed or have fewer staff available to help clients.
7. **On the day of discharge, the transition coordinator and case manager should visit the client in his or her new home** to ensure all services are set up and available. For example, a home health aide should be available to assist with unpacking, a nurse should be present to set up medications, medical equipment should be delivered, etc. In addition, for safety of the client, **there must be a working phone in the home on the day of transition, even if it is a temporary, prepaid cell phone.** (Sometimes phone companies do not install the phone on schedule.)
8. **Transition coordinators may use HOME Choice funds to purchase “start-up” food and clothing,** which is necessary for some residents. This includes shoes, coats, underclothing, etc. In addition, **HOME Choice funds may be used to purchase bus passes** or other transportation vouchers. **Transition coordinators are not permitted to use HOME Choice funds to purchase TVs.** However, we feel a TV is important to many of our clients because it provides a connection to the outside world and helps to keep them informed about possible dangerous weather conditions and more. Transition coordinators may find it necessary to identify other resources to purchase or obtain a TV.

9. **The transition coordinator must work with the nursing home to make sure the resident has enough medications at discharge to last until the resident sees the doctor in the community and/or until the resident's Medicaid status is changed from "NH" to "community."** (Medicaid will not pay for medications until the status is changed.) Consumers usually need at least a one-week supply. In addition, even if the nursing home tells the transition coordinator it will send needed medical supplies with the resident on discharge, it does not always happen. **The transition coordinator and case manager should visit clients on the day of discharge to make sure they have enough of their medications and supplies to last until they see their community physicians to obtain prescriptions.**
10. **It is important for the resident to be the decision maker and to be engaged in the transition process.** If a resident is unable to visit potential apartments, the transition coordinator can take pictures to show him or her what they look like. In addition, if the resident is unable to shop with the transition coordinator for household goods, the transition coordinator can show him or her options via store Web sites. The transition coordinator can also give the resident various tasks, such as making a grocery list, contacting a phone or utility company, packing, working with the social worker to get the medical equipment ordered, etc.
11. With the resident's consent, it is a good idea for the transition coordinator and case manager to review pertinent medical records and talk to family members and various community case managers to **get a clear picture of the resident's needs in order to develop an effective service plan.** Transition coordinators and case managers need to work together to develop the service plan and include HOME Choice demonstration and supplemental services as needed. These services include nursing, counseling, nutritional consultation, independent living skills training, community support coaching, service animals and communication aides.
12. **Some clients do not transition well,** even with all the right support systems and services. This is not necessarily the transition coordinator's or case manager's fault. **Many of our clients are in nursing homes because of lifelong poor decision-making abilities, and the inability to understand consequences.** However, transition coordinators and case managers should use these situations to learn how to improve the HOME Choice transition process.
13. **Clients tend to minimize their needs** when it comes to predicting what services they will need upon discharge. It is important to educate clients that the amount of assistance they need at discharge will not change their enrollment in the program. It is better and easier to have maximum services in place than to add services after discharge.
14. Clients benefit from having homemaker services present at their apartment when they arrive on the day of discharge. Some clients become overwhelmed; it helps if the homemaker can help make their bed, put things away and prepare their first meal. **Homemaker assistance decreases the anxiety that some clients feel that first day.**
15. Throughout the entire HOME Choice experience, remain in contact with all key players (including the case manager, ODJFS, fiscal management service provider, etc.). **Frequent contacts will result in a smoother transition for the client.**
16. **Housing is easier to secure with proof of funds.** Landlords tend to take clients more seriously when they have a deposit in hand.
17. Collaboration with the client's family, friends and/or facility is crucial when coordinating trips outside the nursing facility for shopping, apartment viewings, etc. **This will ensure that the client has all medications, medical equipment, etc., to make the trip comfortable and productive.**
18. Community support coaches can play a vital role, by helping clients understand various processes and agreements that may appear unclear or complicated to them (such as terms of a lease, financial management issues, overall organization, available community services, etc.). They also can encourage clients' self-sufficiency. **Consumers, case managers and transition coordinators need to understand the important role of a community support coach and should include community support coaches in service plans.**
19. **Building relationships with furniture delivery companies can be helpful.** Over time, once companies gain familiarity with the HOME Choice program and the clients that it serves, they sometimes offer setup and assembly services.
20. **Advocate.** After a move is complete, ombudsmen who are providing transition coordination should continue to identify and resolve problems, to ensure a successful transition.

Share HOME Choice Newsletters!

Transition coordinators, case managers, and service and support administrators (SSAs): Please share the *HOME Choice Bulletin* with consumers. Ask them if they would like to be featured in the "Success Story" section. If you know a consumer who is interested in being featured, please e-mail Susan McKinley at Susan.McKinley@jfs.ohio.gov.

2010 Bimonthly Conference Calls to Resume in 2011

A new schedule of technical assistance conference calls is in the works for 2011. Watch for e-mails and the *HOME Choice Bulletin* for an announcement of the calls. If you would like to be notified by e-mail, please contact MFP@jfs.ohio.gov to be added to our listserv.

Housing Update: HUD Awards Ohio Housing Authorities with Vouchers

HOME Choice continues to work with Public Housing Authorities (PHAs) for designating vouchers for people with disabilities moving out of nursing homes.

On October 1, the U.S. Department of Housing and Urban Development (HUD) announced the release of 4,300 vouchers for people with disabilities. Ohio received 490 vouchers worth \$2,651,173. Five Ohio PHAs received vouchers:

- Athens Metropolitan Housing Authority - \$450,804, 100 vouchers
- Butler Metropolitan Housing Authority - \$594,252, 100 vouchers
- Fayette Metropolitan Housing Authority - \$212,202, 50 vouchers
- Lorain Metropolitan Housing Authority - \$592,068, 100 vouchers
- Lucas Metropolitan Housing Authority - \$801,847, 140 vouchers

If you serve in any of the counties receiving vouchers, please advocate for a portion of these vouchers for people you may have on your waiting list. If you have any questions, please call (614) 466-6742.

HOME Choice Rules Amended

ODJFS has amended Ohio Administrative Code (OAC) rules [5101:3-51-01](#), [5101:3-51-02](#), [5101:3-51-03](#), [5101:3-51-04](#), [5101:3-51-05](#) and [5101:3-51-06](#) to clarify policy governing the **HOME Choice (Money Follows the Person) Demonstration Program**.

These rules set forth HOME Choice Demonstration Program definitions, participant eligibility requirements, provider conditions of participation, service specifications and provider requirements, the provider enrollment process, and service rates and reimbursement procedures.

The following are some changes that became effective on September 9, 2010:

- **Program definitions** have been modified to correct terminology and/or offer additional clarity.
- The Centers for Medicare and Medicaid Services (CMS) has approved Residential Treatment Facilities (RTFs) as qualified residences for determining HOME Choice participant program eligibility. Under the HOME Choice Demonstration Program, an RTF is a facility with more than 16 beds, or a facility located on a campus of multiple facilities that total more than 16 beds, that serves children, and that is licensed as a Type 1 residential facility by the Ohio Department of Mental Health in accordance with OAC rule 5122-30-03.
- **Provider conditions of participation** have been amended to address documentation requirements, monitoring and oversight, and to clarify and strengthen policy regarding when to notify the case manager or service and support administrator, and what a provider can and cannot do while furnishing HOME Choice services.
- CMS has approved a **new respite service**, which has been added to the HOME Choice Demonstration Program. It can be provided in the HOME Choice participant's home, in an out-of-home setting or in a day camp setting. In-home respite services will be reimbursed at \$9/hour; out-of-home respite will be reimbursed at \$200/day; and camp respite will be reimbursed at \$125/day or a maximum of \$625/week. Altogether, a HOME Choice participant can receive up to \$2,000 in respite services during the 365-day demonstration period.

- **Nutritional consultation and social work/counseling** have been amended to make them consistent with the service specifications and provider requirements recently developed by ODJFS, the Ohio Department of Aging and the Ohio Department of Developmental Disabilities, under the advisement of the Executive Medicaid Management Agency (EMMA). These service specifications and provider requirements will be adopted by each state agency when such services are added or amended.

Patient Protection and Affordable Care Act (PPACA) Web Site Available

President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 into law in March 2010. These health care reforms aim to expand coverage to millions of Americans and will require many changes to health insurance products and the regulations that govern them.

The following site provides explanations of the different parts of this legislation and additional resources for those who would like to learn more: <http://www.healthcarereform.ohio.gov/Pages/default.aspx>.

HOME Choice Statistics

As this issue of the *HOME Choice Bulletin* went to press:

- 791 consumers were enrolled.
- 2,105 people have applied.

The HOME Choice program accepts referrals from any source. If you know anyone who is interested in transitioning into a community setting, please call the ODJFS HOME Choice Intake and Care Coordination Unit toll-free at 1-888-221-1560 or fax an interest form to 1-614-466-6945. Visit <http://jfs.ohio.gov/OHP/consumers/HOMEchoice.stm> for interest forms and other information.

HOME Choice Vision Statement

Ohioans who need long-term services and support . . .
Get services and supports they need in a timely manner
In settings they want from whom they want,
And if needs change, services and supports change accordingly.

This document was developed under grant CFDA 93.791 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. However, these contents do not necessarily represent policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

The *HOME Choice Bulletin* is a newsletter for stakeholders and anyone interested in Ohio's Money Follows the Person HOME Choice Transition Program. It provides updates, statistics and other information about the status and progress of Ohio's HOME Choice Program several times a year.

Please contact mfp@jfs.ohio.gov if you have comments, information to share, or would like to be added to the *HOME Choice Bulletin* e-mail distribution list.