



TRANSITION COORDINATION SERVICES

WHAT ARE TRANSITION COORDINATION SERVICES?

- The purpose of the Transition Coordination Services program is to provide individuals who reside in nursing homes with long term care Medicaid benefits the opportunity to explore their options for transitioning from the nursing home to a home in the community. In March of 2013, through *A Money Follows the Person* grant, Colorado initiated *Colorado Choice Transitions* (CCT), a transition program. When the CCT demonstration project ended on December 31, 2018, Transition Coordination Services moved under the Colorado State Plan as a Home and Community Based Services (HCBS) waiver program service.
- The Larimer County Office on Aging/Aging and Disability Resources for Colorado (ADRC) contracts with the Colorado Department of Health Care Policy and Financing as the local contact agency (LCA) to provide Transition Coordination Services Options Counseling. This is the first step in the Transition Coordination Services process and helps residents explore their options of moving back to the community from the nursing home.
- Options Counseling is a conversation with a trained professional in the field of aging and disability who helps individuals identify their needs and goals in order to explore long term service and support options. Transition Coordination Options Counseling helps individuals understand their transition options and community resources in order to make informed choices about moving back to the community. In addition, Options Counseling helps individuals understand the Transition Coordination Services process including the support and services provided by the transition coordinator.

WHAT IS THE REFERRAL PROCESS FOR THIS PROGRAM?

- Referrals can be made by nursing home residents, nursing home staff, family members, community members, Long Term Care Ombudsman, or other professionals. An individual must be a current resident of a nursing home to be eligible for this program.

- A person must currently be receiving Long Term Care Medicaid benefits to participate in this program. If an individual has submitted a Long-Term Care Medicaid application, a referral for transition coordination services cannot be made until the individual has been approved for Long Term Care Medicaid benefits.
- If an individual is receiving rehabilitation services under Medicare A or Medicaid benefits, a referral for transition coordination services cannot be made until the individual has completed all rehabilitation therapy services.

WHAT ARE THE STEPS INVOLVED IN THE TRANSITION COORDINATION SERVICES PROCESS?

- After a referral is made to the ADRC, an Options Counselor will meet with the resident one-on-one at the nursing home to discuss transition coordination services and to help that individual explore their options for moving back to the community from the nursing home.
- If an individual is interested in further exploring transitioning back to the community, the Options Counselor will complete a Transition Coordination Services Referral Form and make a referral to one of the transition coordination agencies (TCA) contracted with the State of Colorado to provide transition coordination services.
- The transition coordinator (TC) will meet one-on-one with the individual and assist that person in determining their needs and the feasibility of meeting those needs in the community with the available long-term care Medicaid services and community resources. The transition coordinator will help determine feasibility of a transition, and continue to work with that individual throughout the transition process.

For more information or to make a referral, please call or send an email
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