SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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HOME AGAIN ELIGIBILITY PACKET

You have received the Home Again Eligibility Package because you or someone else made a referral for _____ to the Home Again program. Please complete and return the completed package with nursing facility face sheet to us via fax (803) 255-8209, Attention: Home Again, or email at homeagain@scdhhs.gov.

If this packet is not received within 15 working days upon receipt of this packet, the referral may be terminated. Once the applicant meets preliminary requirements for the Home Again program, a nurse from the CLTC Area Office will complete an assessment and determine the applicant's Level of Care.

If you have any question, please contact Home Again at homeagain@scdhhs.gov.

Sincerely,
Home Again Staff

ELIGIBILITY CHECKLIST

Applicants must meet the preliminary requirements for the Home Again program.

Please answer all of the following questions pertaining to the applicant.

1. **Contact Availability:** Video Conferencing may be required to start the transition planning process.
   - Is participant willing to participate in video conferencing? ☐ Yes ☐ No

     If no, participant will be placed on the Home Again waiting list until face to face contact is can be scheduled.
   - If yes, does participant and/or nursing home have access to necessary equipment for video conferencing in the nursing facility (such as a Tablet, IPad, or Smart Phone): ☐ Yes ☐ No

     What type of equipment is available? _____

     What type of video conferencing application would be utilized (i.e. Google Duo, Zoom, Skype, Facetime, etc.)? _____

     Please provide appropriate contact information for available equipment that will be utilized:

     Telephone number: _____

     Email: _____
2. **SC Medicaid:**
   - Do you currently have South Carolina Medicaid? ☐ Yes ☐ No
   - If yes, is Medicaid the primary funding source for your Nursing Facility services? ☐ Yes ☐ No
   - If no, are you planning to apply for Medicaid? ☐ Yes ☐ No
3. **Qualified Institution:**
   - Are you living in a Skilled Nursing Facility and/or Hospital now? ☐ Yes ☐ No
   - Have you been in the Nursing Facility and/or Hospital for the past 90 consecutive days? ☐ Yes ☐ No

- What is the most recent admission date? _____
- As part of the most recent stay, was the person receiving short-term rehabilitation under Medicare Part A benefit? ☐ Yes ☐ No
- If yes, what was the time period? _____
- Has participant been in any other Nursing Facility, Rehabilitation Facility, or hospital within the last year? ☐ Yes ☐ No
- If yes, what were the admission dates and the discharge dates for each admission?

4. Other

- Is Minimum Data Set (MDS) Section Q your referral source?
  ☐ Yes ☐ No
- Will you be living with your family member(s)?
  ☐ Yes ☐ No
- If yes, what is the name of the primary caregiver/contact?

  _____
- Do you have a place to live in the community? ☐ Yes ☐ No
- If yes, what is the address:

  _____
- Do you need help finding housing? ☐ Yes ☐ No
- If yes, the following documents are required. Please attach the documents to this packet if available.

  - A Copy of Social Security Card
  - A Copy of Birth Certificate (long form)
  - A Copy of Government-issued picture ID
  - Current proof of income

Note: Failure to provide certain information may result in delayed transition or termination of your application.

4. Comments

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HOME AGAIN PROGRAM

INFORMED CONSENT FORM

Applicant Name: _____ Medicaid Number: _____

As part of my application for the Home Again program, my condition must be evaluated by the South Carolina Department of Health and Human Services (SCDHHS), the state agency that administers the Medicaid program in South Carolina.

I choose to participate in the Home Again program to return to the community from a nursing facility. I understand that my medical and social situation must be evaluated in more depth by a SCDHHS representative. Therefore, I consent to allow the SCDHHS representative to obtain and share personal health information about me as follows:

1. I consent that any social service professionals, organizations, doctors, nurses, other medical personnel or medical facilities involved in my care may release to an authorized SCDHHS representative any medical information regarding my diagnosis and recommended treatment.

2. I consent to the release by authorized SCDHHS representatives of information about me to doctors, hospitals, health and human services organizations or agencies, family members and other persons to whom SCDHHS may refer me for care.

3. In the event that SCDHHS representatives reasonably believe that I may be the victim of abuse, neglect or exploitation, I consent to release of information to organizations authorized by law to investigate such reports (Protective Services Divisions of the Department of Social Services, the State Vulnerable Adult Guardian ad Litem Program of the Lieutenant Governor's Office on Aging, local law enforcement, the State Long Term Care Ombudsman, the State Law Enforcement Division, or the Attorney General's Office).

4. Upon the request of the organizations listed in #3, above, I consent to the release by DHHS representatives of information about me to the named organizations.

I understand that once SCDHHS releases information about me to other individuals or organizations, the information will no longer be protected by SCDHHS from re-disclosure. However, most organizations that provide information to or request information from SCDHHS have their own privacy practices that protect disclosure. I also understand that the Home Again program lasts for one year from my discharge date from a nursing facility and I may receive continued long-term care services from the SCDHHS after the one year. I consent the SCDHHS to release my information to the Centers for Medicare and Medicaid Services as appropriate.

This Consent will expire five (5) years after my termination from the Home Again program.

_____ _____

Applicant's Signature Date

_____

If signed by responsible party, state relationship and authority to Sign

_____

Facility Witness (Social Worker or Discharge Planner)