

ABOUT THE IC

The Independence Center (The IC) is a local nonprofit organization that provides traditional and self-directed home health care, independent living, veterans, and advocacy services for people with disabilities. These services range from providing peer support, skills classes, and employment assistance to individual and systems advocacy. In addition, The IC runs a Certified Nurse Aide training program to equip the area with qualified CNAs. The IC's mission is to work with people with disabilities, their families, and the community to create independence so all may thrive.

HOME HEALTH CARE

The IC offers home health care that is licensed and non-licensed, self-directed or physician-directed, for all ages, and with the caregiver or your choice or an employee of The IC.

CNA TRAINING PROGRAM

The Independence Center's CNA Training Program offers day and evening classes to become a qualified Certified Nurse Aide.

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**A NON-PROFIT
ORGANIZATION**
the-ic.org

People with disabilities
building community
**THE
INDEPENDENCE
CENTER**

H2H

HOSPITAL TO HOME



**Assisting people with disabilities to
transition safely from the hospital back into
their homes and communities**

CENTER FOR INDEPENDENT LIVING | ADVOCACY
HOME HEALTH | CNA TRAINING | VETERANS

The Hospital to Home (H2H) program assists people with disabilities to transition safely from the hospital back into their homes and communities. The Care Transition Coordinator (CTC) will work with the hospital on complex discharge cases to determine the best candidate for the program.

WHAT MAKES A PATIENT ELIGIBLE FOR THE H2H PROGRAM?

The eligibility criteria that a patient must meet to be considered for the H2H program is as follows:

- The patient must have a disability.
- The patient must have a home or place to live upon discharge.
- The patient must have family or a support system to help with their transition and care.

HOW DOES THE H2H PROGRAM WORK?

The CTC will coordinate any community resources that are needed once the patient has safely discharged from the hospital back home, giving you one point of contact who will help you in areas.

The CTC will continue to be a support for the patient temporarily until the patient is stable and connected with community resources necessary to avoid being readmitted to the hospital.

TEMPORARY CASE MANAGEMENT THAT CAN ASSIST WITH:

- Transportation from the hospital to home
- Meals
- Medication (fill/delivery)
- Benefits
- Home evaluations
- Peer support
- DME assistance
- Any skilled care, if necessary.
- Guidance with community resources (such as support groups and training family and friends)

For more information,
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