

ATTACHMENT F TRANSITION PLAN

PARTICIPANT INFORMATION

LAST NAME, FIRST NAME		DATE OF BIRTH	
PHONE		EMAIL	
MEDICAID #	MFP APPROVAL DATE	DATE TRANSITION PLAN STARTED	
ADDITIONAL COMMENTS REGARDING THE INDIVIDUAL THAT MAY BE PERTINENT			

SME CONTRACTOR INFORMATION

CONTRACTOR NAME	TRANSITION COORDINATOR NAME
TRANSITION COORDINATOR PHONE	TRANSITION COORDINATOR EMAIL
MFP REGIONAL COORDINATOR	REGION
ADDITIONAL COMMENTS REGARDING THE SME CONTRACTOR THAT MAY BE PERTINENT	

NURSING HOME INFORMATION

FACILITY NAME		FACILITY PHONE	DATE OF ADMISSION
ADDRESS			COUNTY
CONTACT PERSON	CONTACT PERSON PHONE	CONTACT PERSON EMAIL	
ADDITIONAL COMMENTS REGARDING THE NURSING HOME THAT MAY BE PERTINENT			

COMMUNITY HOME ADDRESS

COMPLETE AFTER CHOICE OF COMMUNITY HOUSING HAS BEEN DETERMINED		
ADDRESS	COUNTY	PHONE

PERMISSION STATEMENT

<p>I affirm I have met with the Transition Coordinator listed below and I have given my permission to my Transition Coordinator and their employing organization to assist me with transitioning from the above facility. We will develop a plan that shows my supports and goals to live in the community. I understand that changes can be made, and this Plan serves as a guide to help me with my transition. I also understand the Transition Coordinator and/or their employing organization is to provide me with information, supports, and resources that will help me make a successful transition to the community.</p>	
TRANSITION COORDINATOR NAME	TRANSITION ORGANIZATION NAME
PARTICIPANT SIGNATURE	DATE

CONTRACTOR ACTIONS

<input type="checkbox"/> Provide participant with MFP brochures/Pamphlets
<input type="checkbox"/> Complete this Transition Plan in its entirety with the Transition Team (participant, nursing home, family, doctor, legal representative, DSDS SME Regional Coordinator)
<input type="checkbox"/> Tour housing unit to identify any issues
<input type="checkbox"/> Complete the Emergency Plan in its entirety
<input type="checkbox"/> Send Transition Plan to the Regional Coordinator once complete

MEDICAL INFORMATION

Will your doctor continue to see you once you move into the community?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If no, have you identified a doctor in the community who will accept you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• If you have identified a doctor able to accept you once you move into the community, do you have an appointment within 2 weeks of transition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will your doctor prescribe a 30-day supply of medication?	<input type="checkbox"/> No Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you selected a pharmacy?	<input type="checkbox"/> No Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your pharmacy deliver medications to your home?	<input type="checkbox"/> No Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
DOCTOR NAME	PHARMACY NAME	
DOCTOR TELEPHONE	PHARMACY TELEPHONE	
DOCTOR ADDRESS	PHARMACY ADDRESS	
Has a referral ever been made due to concerns about your health, safety, or well-being?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, EXPLAIN IN DETAIL		

MENTAL HEALTH NEEDS

Have you received mental health services or counseling in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like a referral to a mental health provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking medication/treatment requiring regular mental health follow-up visits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a preference for a mental health provider	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, PROVIDER NAME	PROVIDER ADDRESS	PROVIDER PHONE
IF YES, DESCRIBE THE MENTAL HEALTH PLAN INCLUDING ELIGIBLE PROGRAMS, RESOURCES, AND SUPERVISION PHYSICIAN:		
Do you have a history or alcoholism or drug abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, EXPLAIN CIRCUMSTANCES		
IF YES, EXPLAIN THE SUBSTANCE ABUSE PROGRAM INCLUDING COUNSELING/TREATMENT DATE AND TIMES		

PERSONAL HEALTH NEEDS (Please attach Plan of Care)

Do you have your physician's approval for nursing home transition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need assistance with bathing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES: <input type="checkbox"/> Bathing in the bathtub <input type="checkbox"/> Bathing in the Bed <input type="checkbox"/> Spongebath		
Do you need assistance with dressing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES: <input type="checkbox"/> Lower extremities <input type="checkbox"/> Upper extremities		
Do you need assistance with toileting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES: <input type="checkbox"/> Getting on/off commode <input type="checkbox"/> With pads		
Do you need assistance with bladder care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES: <input type="checkbox"/> Catheter <input type="checkbox"/> Urinal <input type="checkbox"/> Other		
Do you need assistance with bowel care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES: <input type="checkbox"/> Suppositories <input type="checkbox"/> Laxatives <input type="checkbox"/> Other		
Do you need assistance with eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES: <input type="checkbox"/> Feeding <input type="checkbox"/> Setup <input type="checkbox"/> Cutting Food <input type="checkbox"/> Clean up <input type="checkbox"/> Meal preparation		
Do you need assistance with housekeeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES: <input type="checkbox"/> Dusting <input type="checkbox"/> Mopping <input type="checkbox"/> Vacuuming <input type="checkbox"/> General Cleaning <input type="checkbox"/> Other		
Do you need assistance transferring from one place to another?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES: <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Pivot Lift <input type="checkbox"/> Staff to assist with equipment <input type="checkbox"/> Other		
PROVIDE THE NAMES OF THREE (3) SUPPORTIVE FAMILY MEMBERS, FRIENDS, OR COMMUNITY ADVOCATES		
NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

ASSISTIVE TECHNOLOGY/DEVICES – *For additional assistance, call MOAT (800) 647-8557*

Do you currently use any assistive technology devices or Durable Medical Equipment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, DESCRIBE		
Do you need any assistive devices or Equipment to increase your independence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, DESCRIBE		
Are you interested in an Assistive Technology Assessment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Assistive Technology or DME is required: have you ordered the equipment?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
do you have a plan to pay for it?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
do you need funding assistance?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you worked out delivery?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
do you need training to use?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No

FURNISHINGS

Have you completed the attached transition checklist detailing what possessions you have and what possessions you will need to purchase before transition takes place?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have money to buy additional wants and needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of places which may donate furnishings?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you coordinated your move?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need assistance moving?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need assistance setting up your new home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

TRANSPORTATION

Are you able to take care of your transportation needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need specialized transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you know how to schedule appointments to use specialized transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEAL PLANNING

Do you need independent living skills training in this area?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you coordinated a plan so you can purchase, cook, and eat meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a special or complex diet regimen you must follow?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Who will do the initial shopping for groceries and supplies?	NAME/RELATIONSHIP	

SOCIAL AND LEISURE ACTIVITIES

Are you able to familiarize yourself with your new neighborhood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need assistance in meeting your new landlord and neighbors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need assistance in planning daily or weekly social activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you want skills training to assist you with any of these activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What activities do you plan on doing to keep yourself busy once you return home?		

EMPLOYMENT/VOLUNTEERING

Are you interested in joining or re-joining the workforce?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, DESCRIBE		
Is there any history that would prevent you from a particular job or volunteering?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like to learn a new trade or go back to school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like to volunteer somewhere?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like to meet with a Benefits Specialist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a referral been made to Missouri Division of Vocational Rehabilitation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like to contact Missouri Division of Vocational Rehabilitation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

GENERAL NEEDS PLAN ACKNOWLEDGEMENT

I hereby affirm I have completed the General Needs Transition Plan with my Transition Coordinator on the following date:	
Participant Signature	Transition Coordinator Signature

BUDGETING AND FINANCE

Review the following questions with the participant and document their response as well as any concerns or other items on otherwise listed.		
INCOME TYPE(S) – BANK ACCOUNTS, ASSETS, SS/SSI/SSDI, FAMILY MEMBERS, PENSIONS, AND EMPLOYMENT		
Are there benefits you need assistance applying for?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, DESCRIBE		
Who currently manages your finances? <input type="checkbox"/> Self <input type="checkbox"/> Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Payee <input type="checkbox"/> Conservator <input type="checkbox"/> Durable Power of Attorney		
If you manage your own finances, do you use a budget?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the nursing home receive your income checks and give you an allowance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you receive your check and pay the nursing home yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FUNDING RESOURCES

Due date for Medicaid Review		
Person who assists you with Medicaid Reviews		
Is your Medicaid transferable to another Medicaid program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you requested a transfer to another Medicaid program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, LIST THE NAME AND PHONE NUMBER OF THE PERSON ASSISTING WITH THE TRANSFER		
Did you have a Spenddown prior to entering the nursing home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, AMOUNT	If yes, are you able to meet your spenddown once you move out?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was spenddown discussed with you during your options counseling session?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need assistance with spenddown paperwork?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you or your spouse a Veteran in the United States Armed Forces?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you started transferring your SSI/SSDI from the nursing home to the community?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
IF YES, WHEN WAS THE PROCESS STARTED:		

INCOME WORKSHEET

INCOME SOURCE	MONTHLY AMOUNT	COMMENT
SSI	\$	
SSDI	\$	
SSA	\$	
Railroad Retirement	\$	
Pension	\$	
Employment	\$	
Other	\$	
Other	\$	
TOTAL MONTHLY INCOME	\$	

EXPENSE WORKSHEET

INCOME SOURCE	MONTHLY AMOUNT	COMMENT
Rent/Mortgage	\$	
Homeowner/Renter Insurance	\$	
Property Taxes	\$	
Home Repairs/Maintenance/Dues	\$	
Home Improvements	\$	
Electric	\$	
Water/Sewer	\$	
Natural Gas	\$	
Propane	\$	
Telephone – Landline	\$	
Telephone – Cell Phone	\$	
Groceries	\$	
Restaurant Meals	\$	
Cleaning Supplies	\$	
Laundry Supplies	\$	
Personal Care Supplies	\$	
Clothing	\$	
Child Care	\$	
Alimony	\$	
Child Support	\$	
Medical Insurance/Spenddown	\$	
Medical Co-Pays	\$	
Medical Supplies	\$	
Fitness	\$	
Car Payment	\$	
Auto Insurance	\$	
Auto Fuel	\$	
Auto Repairs/Maintenance/Fees	\$	
Personal Property Taxes	\$	
Taxis and Other Transportation	\$	
Credit Cards	\$	
Student Loans	\$	
Other Loans	\$	
Cable/Satellite TV	\$	
Internet	\$	
Hobbies	\$	
Subscriptions/Dues	\$	
Vacations	\$	
Pet Food/Grooming/Vet Care	\$	
Other	\$	
Other	\$	
TOTAL MONTHLY EXPENSES	\$	
TOTAL MONTHLY INCOME LESS TOTAL MONTHLY EXPENSES		\$
COMMENT REGARDING NET INCOME		

FINANCE AND BUDGET PLAN ACKNOWLEDGEMENT

I hereby affirm I have completed the Finance and Budget Transition Plan with my Transition Coordinator on the following date:	
Participant Signature	Transition Coordinator Signature

HOUSING

Review the following questions with the participant and document their response as well as any concerns or other items on otherwise listed.			
WHERE ARE YOU PLANNING TO LIVE/MOVE?			
Have you obtained a housing life from the Transition staff?			<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the realistic TARGET move date? (at least 3 months is recommended)			
What city would you like to live in?			
If housing is unavailable, are you interested in living in another city?			<input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, WHERE?			
Are you receiving any help with paying for your housing?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Review housing options with the participant. Please indicate their first and second choices.			
FIRST CHOICE		SECOND CHOICE	
Home/Apartment		Home/Apartment	
Address		Address	
Contact		Contact	
Housing Phone		Housing Phone	
Rent	\$	Rent	\$
Avg. Utilities	\$	Avg. Utilities	\$
Deposit Amount	\$	Deposit Amount	\$
Is it Accessible	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is it Accessible	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pet Allowed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Pet Allowed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Pet Cost	\$ <input type="checkbox"/> N/A	Pet Cost	\$ <input type="checkbox"/> N/A
Waiting List	<input type="checkbox"/> Yes <input type="checkbox"/> No	Waiting List	<input type="checkbox"/> Yes <input type="checkbox"/> No
Length of Wait		Length of Wait	
Are you on Waitlist	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on Waitlist	<input type="checkbox"/> Yes <input type="checkbox"/> No
LIVING ARRANGEMENTS			
<input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> With Friends <input type="checkbox"/> With Roommates <input type="checkbox"/> Other			
IF ALONE, WHO WOULD YOU CALL IF YOU NEEDED ASSISTANCE?			
Name:		Phone:	Relationship:
Do you have any type of criminal history which could prohibit you from living in some housing complexes?			<input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, EXPLAIN			
Do you have past evictions, unpaid rent or poor credit history which might impact you living in subsidized housing?			<input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES, EXPLAIN			
Do you want internet? If yes, pricing: \$			<input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER CONCERNS/ITEMS OF INTEREST			

HOUSING INSPECTION

Upon inspection of the property(s), please indicate any issues or concerns that must be addressed prior to transitioning the participant into this housing.

EXPLAIN

Property Address

HOUSING INSPECTION

Date of Lease		Participant Reviewed Lease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date Housing Secured		Date to Receive Keys		
Date Rent/Deposit Paid		Scheduled Move Date		
Utilities Hook-Up		Telephone Hook-Up		
Cable/Satellite Hook-Up		Duplicate Keys Made	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Internet Hook-Up		Duplicate Keys Given To		

UTILITIES

Have you scheduled an appointment for telephone service to be installed?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, date service will be turned on				
Have you scheduled an appointment for electricity to be turned on?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, date service will be turned on		Do you owe back payments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you scheduled an appointment for gas to be turned on?			<input type="checkbox"/> N/A	<input type="checkbox"/> Yes
If yes, date service will be turned on		Do you owe back payments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you requested the Post Office change your address?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

HOUSING PLAN ACKNOWLEDGEMENT

I hereby affirm I have completed the Housing Transition Plan with my Transition Coordinator on the following date:

Participant Signature

Transition Coordinator Signature

24- HOUR EMERGENCY BACKUP PLAN ACKNOWLEDGEMENT

I hereby affirm I have completed the 24-Hour Emergency Backup Plan with my Transition Coordinator on the following date: . A copy of the plan has been provided to me.

Participant Signature

Transition Coordinator Signature

NURSING HOME CONTACT DATES/DISCHARGE NOTES

Document any communication/information regarding the assistance in this transition:

24-HOUR EMERGENCY BACKUP

This plan is for the safety and well-being of the participant. It identifies how to respond to and address any lapse in essential services and other circumstances that could have a negative effect on participant health, safety, or welfare. In case of an emergency intervention, the contractor has permission to contact local authorities.			
PARTICIPANT NAME			
Do you have a Lifeline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	NOTE
Do you have an Emergency Dialer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	NOTE
Do you have support from a provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	PROVIDER NAME
IF THERE ARE OTHER AGREED UPON RESOURCES INCLUDING FORMAL & INFORMAL SUPPORTS, PLEASE DESCRIBE			
PRIMARY 24-HOUR CONTACT		OTHER EMERGENCY CONTACT	
Contact Name		Contact Name	
Address		Address	
Phone		Phone	
OTHER EMERGENCY CONTACT		OTHER EMERGENCY CONTACT	
Contact Name		Contact Name	
Address		Address	
Phone		Phone	
Do you use any adaptive equipment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	IF YES, DESCRIBE
Do you use oxygen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you use a wheelchair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	IF YES <input type="checkbox"/> Manual <input type="checkbox"/> Electric EXTRA BATTERIES? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is home owned or rented?			<input type="checkbox"/> Owned <input type="checkbox"/> Rented
LANDLORD NAME		LANDLORD PHONE	
Home has smoke detectors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	LOCATION
Home has fire extinguisher?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	LOCATION
Flashlights?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	LOCATION
Travel/Emergency Radio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	LOCATION
Emergency Supplies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	LOCATION
Community's Warning Signal	<input type="checkbox"/> Siren	<input type="checkbox"/> Whistle	<input type="checkbox"/> Flashing Device <input type="checkbox"/> Unknown
How do you heat your home?	<input type="checkbox"/> Electric	<input type="checkbox"/> Gas	<input type="checkbox"/> Other:
How do you heat your water?	<input type="checkbox"/> Electric	<input type="checkbox"/> Gas	<input type="checkbox"/> Other:
What type of stove do you have?	<input type="checkbox"/> Electric	<input type="checkbox"/> Gas	<input type="checkbox"/> Other:
Microwave?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pets? <input type="checkbox"/> N/A	<input type="checkbox"/> Dog	<input type="checkbox"/> Cat	<input type="checkbox"/> Bird <input type="checkbox"/> Other:
Prescribed Medications & Frequency	ATTACH LIST FROM PHARMACY		
Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	TYPE
If yes, describe location and frequency			
What is your likelihood of receiving transportation in case of an emergency?		<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Maybe <input type="checkbox"/> Unlikely	
Have you received Ready-in-3 Emergency Info?		<input type="checkbox"/> Yes <input type="checkbox"/> No	