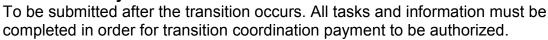
## **Money Follows the Person Transition Final Checklist**





Date.			Doguest submitted by	
Participant's Name:			Request submitted by:	
Participant's Medicaid Number:				
			□ PACE	
TAY ID/ FIN # (require	i ivaille		☐ MCO	
TAX ID/ EIN # (required): Phone: Fax: Transition Date:			□ DVR-IL	
Transition Date:				
Task ✓ Notes				
Initial Transition Planning Conversation Held		Date:		
Final Transition Planning Conversation Held		Date:		
Final Transition Plan submitted to MFP		Date:		
Final briefing meeting with MFP held <b>before</b>		Phone meeting is sufficient		
transition occurred.		Date:		
Quality of Life Survey C	onducted and		Can be submitted with this checklist	
submitted to MFP		Date:		
First transition follow up meeting with		Date Scheduled:		
participant				
DSS has added CAP indicator		Date added:		
Did Medicaid County change?YesNo		If yes, what County?		
Who is the follow along		Name:		
Example: CAP/DA, PACE, CCNC, MCO Phone #				
Address of Participant's Community Residence in North Carolina				
Street:				
City: County			Zip:	
Phone #: Alternate Phone #:				
Final Living Arrangement (Check one)				
In own home	In relative's home or a	partment □ Ir	apartment 🗆	
AFL □	Or In 4-bed or less gre	oup home (4 unrel	ated individuals) 🛛	
Waiver Program (Check one)				
Waiver program Participant enrolled in:				
CAP DA CAP Choice PACE CAP MR/ IDDSub CAP				
Transition Coordinator's Signature Da			Date	
Authorized Signature of Sponsoring Lead Agency Representative Date				
Additional of Spondoning Load Agono, Noprodoniative				
MFP Project Authorized Signature for Approval Date				
MED the early Date Cylenditted to Dydret Office				
MFP Use only: Date Submitted to Budget Office Amount \$				
Billing Code Memo Line				