Money Follows the Person Transition Final Checklist

To be submitted after the transition occurs. All tasks and information must be completed in order for transition coordination payment to be authorized.

Date: _____
Participant's Name: _____
Participant's Medicaid Number: _____
LEAD Agency's Name: _____
Transition Coordinator Name: _____
TAX ID/ EIN # (required): _____
Phone: _____ Fax: _____
Transition Date: _____

Request submitted by:
- ☐ **CAP DA/CHOICE**
- ☐ **PACE**
- ☐ **MCO**
- ☐ **DVR-IL**
- ☐ **CIL**

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 **before** transition occurred.		Phone meeting is sufficient Date:
Quality of Life Survey Conducted and submitted to MFP		Can be submitted with this checklist Date:
First transition follow up meeting with participant		Date Scheduled:
DSS has added CAP indicator		Date added:
Did Medicaid County change? __Yes __No		If yes, what County?
Who is the follow along LEAD Agency? Example: CAP/DA, PACE, CCNC, MCO		Name: 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 apartment ☐	In apartment ☐
AFL ☐	Or In 4-bed or less group home (4 unrelated individuals) ☐	

Waiver Program (Check one)
Waiver program Participant enrolled in: __ CAP DA __ CAP Choice __ PACE __ CAP MR/ IDD __Sub CAP

_____ _____
Transition Coordinator's Signature Date

_____ _____
Authorized Signature of Sponsoring Lead Agency Representative Date

_____ _____
MFP Project Authorized Signature for Approval Date

MFP Use only: Date Submitted to Budget Office_____ Amount $_____
Billing Code _____ Memo Line_____