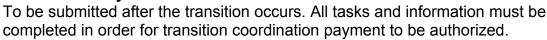
## **Money Follows the Person Transition Final Checklist**





Date:			Daniel III	
Participant's Name:			Request submitted by:	
Participant's Medicaid Number:			☐ CAP DA/CHOICE	
LEAD Agency's Name: Transition Coordinator Name:			☐ PACE	
Transition Coordinato	r Name:			
TAX ID/ EIN # (required): Fax:			□ DVR-IL	
Phone: Fax:			☐ CIL	
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 w	vith 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 ch	ange?YesNo	If yes, what Cou	If yes, what County?	
Who is the follow along	LEAD Agency?	Name:		
Example: CAP/DA, PACE, CCNC, MCO Phone #				
Address of Participant's Community Residence in North Carolina				
Street:				
City: Count		ty:	Zip:	
Phone #: Altern		nate Phone #:		
Final Living Arrangement (Check one)				
In own home	In relative's home or a	apartment 🗆 Ir	apartment 🗆	
AFL □	Or In 4-bed or less gi	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/ IDDSub CAP				
Transition Coordinator's Signature Date				
Duto				
Authorized Signature of Sponsoring Lead Agency Representative			e Date	
Authorized Signature of Sportsoning Lead Agency Representative Date				
MFP Project Authorized Signature for Approval			Date	
MFP Use only: Date Submitted to Budget Office Amount \$				
Billing Code Memo Line Amount \$				
Bining Code Memo Line				