Print Form

NC MFP Supplemental Support Options Planning

Name of MFP Participant: _____

MY SUPPORT NEEDS (i.e. Assessment) To Be Completed At the Beginning of the Transition Planning Process				
Activity	**I Need A Lot of Support (hands on assistance, people to be nearby most of the time, etc.)**	**I Need Some Support (I may need some help with some of these tasks, but not all of them; I need support sometimes but not all of the time)**	**I Don't Need Any Support—I can do it myself.**	**Notes**
Moving around (ambulation, not transportation)				
Transfers				
Bathing				
Getting Dressed				
Going to the Restroom/My Toileting Needs				

Eating My Meals				
Taking my medication/remembering to take my medication				
Preparing My Meals (cooking, shopping for food).				
Budgeting/Managing My Money				
Getting Around Town (transportation—learning to ride the bus, arrange for transportation,)				

Service Package Selected:	**CHECK ONE**	**Notes**
CAP DA		CCNC also included
PACE		
PCS		CCNC also included
CCNC Only		

Our Discussion of My Potential Risks and Our Plan for Preventing and Addressing Them (Risk Mitigation, Back Up Supports and Ensuring Informed Decision Making)					
Topic Area	**The potential risk/issue**	**Our plan to prevent/minimize this risk/issue from occurring**	**If the plan falls through, our back up strategy is:**	**Applicable backup contact information**	**I understand if this issue is not addressed, I'm at risk of:**
Staffing/Support Schedule • MUST have backup plan for critical services, regardless of time of day.					
Housing (including compliance with apartment's rules and lease requirements, feeling safe in new community residence)					
Medical Supports (Accessing medical care, including transportation					
Risks related to chronic conditions					

Our Discussion of My Potential Risks and Our Plan for Preventing and Addressing Them (Risk Mitigation, Back Up Supports and Ensuring Informed Decision Making)					
Topic Area	**The potential risk/issue**	**Our plan to prevent/minimize this risk/issue from occurring**	**If the plan falls through, our back up strategy is:**	**Applicable backup contact information**	**I understand if this issue is not addressed, I'm at risk of:**
I may have (diabetes, wound care, etc)					
Medications (including remembering to take my medication, picking up prescriptions, side effects etc.)					
Adaptive Equipment (including who to call if equipment has issues, etc.)					
Mental Health Supports (including accessing proper mental health supports, keeping appointments, etc.)					
Substance Addiction (including accessing proper					

Our Discussion of My Potential Risks and Our Plan for Preventing and Addressing Them (Risk Mitigation, Back Up Supports and Ensuring Informed Decision Making)					
Topic Area	**The potential risk/issue**	**Our plan to prevent/minimize this risk/issue from occurring**	**If the plan falls through, our back up strategy is:**	**Applicable backup contact information**	**I understand if this issue is not addressed, I'm at risk of:**
substance addiction supports, keeping appointments					
Money Management (including setting a household budget, etc.).					
Transportation					
Family Dynamics					
Preventing Isolation including • Community Involvement					

Our Discussion of My Potential Risks and Our Plan for Preventing and Addressing Them (Risk Mitigation, Back Up Supports and Ensuring Informed Decision Making)					
Topic Area	**The potential risk/issue**	**Our plan to prevent/minimize this risk/issue from occurring**	**If the plan falls through, our back up strategy is:**	**Applicable backup contact information**	**I understand if this issue is not addressed, I'm at risk of:**
• School, Volunteerism or Employment • Leisure • Other					
Risks that Come from My History, Personality, or that I think are just important to include:					

MY SCHEDULE (Service Plan)

Describe How You Would Like to Arrange Your Schedule (include times/activities you want paid assistance, times/activities you do solo, times/activities you have friends and family involved)?

	Desired Schedule (Complete at start of transition process)	**Actual Schedule** (completed after supports/activities secured before transition occurs) Be sure to include the service/activity, the length/time of service/activity, and what days the service/activity will occur	
		Monday- Friday	**Saturday - Sunday**
Early Morning			
Late Morning			
Early Afternoon			
Late Afternoon			
Early Evening			
Late Evening			
Overnight			

Our Post-Transition Follow Up Visit Schedule To be completed BEFORE the transition occurs. Visits after first month can be scheduled prior to the next visit.			
MONTH	**For our transition, this month will be:**	**Minimum Meeting Frequency (more if needed)**	**Scheduling considerations, including first month's meeting schedule**
First Month after Transition		Weekly, in-person	
Second Month after Transition		Every other week, in-person	
Third Month after Transition		Monthly, in person	
Fourth-Tenth Month after Transition		Monthly, either in person or by phone	
Eleventh Month after Transition		Monthly, in person or by phone. Also will do Quality of Life Survey and CAP DA Level of Care	
Twelfth Month after Transition		One in-person meeting:	

SIGNATURES & COMMITMENTS
To be Signed BEFORE the Transition Occurs

By signing below, I am agreeing to the decisions we have made through my planning process, including those decisions outlined in:

1. My Support Needs
2. My Transition Planning Tool
3. Our Discussion of Risks
4. My Schedule
5. Our Post-Transition Follow Up Visit Schedule
6. Quality of Life Pre-transition Survey (voluntary, but included in this list in order to prompt completion)

I understand that issues with my services, supports and/or lifestyle:

1. may affect my ability to remain in the MFP program;
2. may result in the notification of Adult Protective Services if my health, safety or welfare is in jeopardy and/or
3. may result in reinstitutionalization.

_____ _____

Signature of MFP Participant **Date**

_____ _____

Signature of Essential Natural Support Person (if applicable) **Date**

As a transition coordinator signing below, I agree with the decisions we have reached through the planning process and have facilitated the transition planning process in a way that ensures a thoughtful, organized transition. I have also completed each of the transition documents listed above.

_____ _____

Signature of Transition Coordinator **Date**