NC Money Follows the Person (MFP) Demonstration Project
Transition Readiness Tool

This tool is a transition planning tool. While you can use it throughout the transition planning process, it must be referenced and documented two times during the transition process. The first is during the initial planning phase between the time of your first face-to-face meeting with the Participant and the Initial Transition Planning Team meeting. The second time is during final transition briefing phase which takes place between the Final Transition Team Planning meeting and the Pre-Transition Briefing meeting to validate all services and supports will be in place on the day of transition, confirming all transition team members know who is responsible for acting on specific transition aspects, and all transition aspects are reviewed.

Not all questions will apply to every participant, but they are referenced here as prompts to consider when exploring necessary services and supports, as well as desired services and supports. In addition, you may find that you will document more in one section or another, therefore there are no limits to the amount of content you provide in response to any question. Please reference your transition training documents for guidance on completing the different sections.

This document will be submitted to the Department within ten (10) State Business Days following a completed transition. It is a complementary document to the monthly Transition Coordination Workbook. It is also separate from any transition plan that may be completed by a CAP/DA Case Management Entity or PACE organization.

Table of Contents

The tool is separated into sections with chapters that are color coded. The sections and chapters are as follows:

Participant Demographics and Transition Preparation Information:		
Participant Identification and Contact Information		
Participant's First Name:	**Participant's Middle Name:**	**Participant's Last Name:**
Participant's Date of Birth:	**Participant's Medicaid ID Number (MID):**	**Participant's Current Medicaid County:**
Participant's Phone #:	**Participant's Email Address:**	
Participant's Current Facility Name:		
Current Facility Street Address:		
City:	**County:**	**Zip Code:**
Facility Social Worker Name:	**Facility Social Worker Email Address:**	
Facility Social Worker Phone #:	**Facility Social Worker Secondary Phone #:**	**Facility Social Worker Fax #:**
Facility Alternate Contact Name:	**Facility Alternate Contact Email Address:**	
Facility Alternate Contact Phone #:	**Facility Alternate Contact Secondary Phone #:**	**Facility Alternate Contact Fax #:**
Representative / Alternate Contact Name:	**Representative / Alternate Contact Email Address:**	
Representative / Alternate Contact Relationship to Participant:	**Representative / Alternate Contact Phone #:**	

Transition Preparation Information: Initial Transition Planning	
Perspectives on Why Transitioning Matters	
Participant's Perspective	**Other Perspectives**
From the Participant's perspective, why did the Participant come to facility in the first place?	**From others' perspectives, why did the Participant come to the facility in the first place?**
From the Participant's perspective, what is the Participant looking forward to after transitioning and living in their own home?	**From others' perspectives, what is the Participant looking forward to after transitioning and living in their own home?**
From the Participant's perspective, what's working?	**From others' perspectives, what's working?**
From the Participant's perspective, what is not working?	**From others' perspectives, what is not working?**
From the Participant's perspective, what do people need to know about supporting them?	**From others' perspectives, what do people need to know about supporting the Participant?**

Transition Preparation Information: Initial Transition Planning	
Perspectives on Why Transitioning Matters	
From the Participant's perspective, what do people like and admire about them?	**From the others' perspectives, what do people like and admire about the Participant?**
Based on what has been shared, from the Participant's perspective, what is Important TO them?	**Based on what has been shared, from others' perspectives, what is Important TO the Participant?**
Based on what has been shared, from the Participant's perspective, what is Important FOR them?	**Based on what has been shared, from others' perspectives, what is Important FOR the Participant?**
What more needs to be known for the transition planning process?	

Participant Demographics and Transition Preparation Information:		
Key Documents		
Document Type (As Applicable)	**Obtained**	**Comments**
Birth Certificate (Certified Copy) (Required for Targeted/Key Housing)	☐ Yes ☐ No ☐ N/A	
Photo ID (State Issued) (Required for Targeted/Key Housing)	☐ Yes ☐ No ☐ N/A	
Social Security Award Letter (Required for Targeted/Key Housing)	☐ Yes ☐ No ☐ N/A	
Social Security Card (Required for Targeted/Key Housing)	☐ Yes ☐ No ☐ N/A	
Advanced Directive(s)	☐ Yes ☐ No ☐ N/A	
Advocate (Paid or Unpaid)	☐ Yes ☐ No ☐ N/A	
Conservatorship	☐ Yes ☐ No ☐ N/A	
Credit Report	☐ Yes ☐ No ☐ N/A	
Guardianship	☐ Yes ☐ No ☐ N/A	
Offender Report	☐ Yes ☐ No ☐ N/A	
Power of Attorney	☐ Yes ☐ No ☐ N/A	
REAL ID	☐ Yes ☐ No ☐ N/A	
Representative Payee	☐ Yes ☐ No ☐ N/A	
Veteran ID (DD264)	☐ Yes ☐ No ☐ N/A	
Other:	☐ Yes ☐ No ☐ N/A	

Participant Demographics and Transition Preparation Information:
From the Clinical Records: **Institutional History and Circumstances Surrounding Admission**
Relevant Institutional History (give short explanation) (e.g. How many facilities has the participant been in over the last year? How long were they at each facility?)
Who made the decision that the participant be placed in the facility (check all that apply) ☐ Participant (Self) ☐ Family Member(s) ☐ Guardian/POA ☐ Doctor ☐ Other If checked, explain:
Circumstances surrounding admission (details of why the participant was admitted, reason in the Qualified MAP assessment, medical diagnosis, etc.). Check all that apply. ☐ Abuse leading to long-term care ☐ Behaviors ☐ Criminal justice placement ☐ Fall leading to long-term care ☐ Heart attack ☐ Injurious to others/self ☐ Less restrictive option was not previously available ☐ Loss of home and community-based resource/services ☐ Loss of parent/family member/guardian ☐ Loss of unpaid/natural supports ☐ Stroke ☐ Traumatic Brain Injury (TBI) ☐ Vehicular accident leading to long-term care ☐ Other accident leading to long-term care (describe below) ☐ Other health condition complication of (describe below)
Other comments/explanation of circumstances leading to admission

Was substance use a contributing factor to institutionalization? ☐ Yes ☐ No Comments:

SAMPLE
FOR RFP

Participant Demographics and Transition Preparation Information:
Risk Identification and Preventative Measures
Is there a risk associated with any of the following? ☐ Adverse reports from the facility within the last 6 months ☐ Chronic conditions (e.g. history of bowel obstruction, diabetes, wound care, etc.) ☐ Cognitive impairment (ex. dementia) ☐ Equipment dependence (i.e. DME, assistive technology, etc.) ☐ Fall risk ☐ Has had a behavioral health crisis within the last year ☐ Has not lived independently within the last 5 years (or ever) ☐ Has not managed a home & community-based household budget within the last 3 years ☐ History of abuse, neglect, or exploitation prior to institutionalization ☐ History of bowel obstruction ☐ History of choosing not to follow prescribed medication or medical treatment plans ☐ History of hospitalization/ER visits while in the facility ☐ History of personal/domestic violence ☐ In-home aid provider shortage in the county ☐ Interactions with law enforcement ☐ Substantiated APS report regarding the participant ☐ Other (Describe):
What preventative measures can be considered for mitigating these risks?

Participant Demographics and Transition Preparation Information:			
Advanced Directives			
Does the participant have an Advanced Directive? ☐ Yes ☐ No			
If no, does the Participant want one? ☐ Yes ☐ No If yes, indicate below:			
Advance Directive Type	**Was a Copy Obtained**	**Date Obtained**	**Status/ Comments**
Do Not Resuscitate (DNR) ☐ **Yes** ☐ **No**	☐ Yes ☐ No		
Do Not Intubate (DNI) ☐ **Yes** ☐ **No**	☐ Yes ☐ No		
Living Will ☐ **Yes** ☐ **No**	☐ Yes ☐ No		
Medical Power of Attorney ☐ **Yes** ☐ **No**	☐ Yes ☐ No		
Other: ☐ **Yes** ☐ **No**	☐ Yes ☐ No		
Other: ☐ **Yes** ☐ **No**	☐ Yes ☐ No		

Participant Demographics and Transition Preparation Information:

Authorized Decision Makers

Provide contact information on any authorized decision maker for the participant.

Note: If you have more individuals to list, please add more pages.

If there are no contacts, please mark N/A in the section.

Select Type (1)

☐ **Conservator** ☐ **Durable POA** ☐ **Healthcare POA** ☐ **Representative Payee**

☐ **Paid Advocate** ☐ **Patient Advocate** ☐ **Guardian (Private/Family)** ☐ **Guardian (Public/Corporate)**

☐ **Other (e.g. family member who does not have legal status)** ☐ **N/A**

If other, describe relationship:

Name	**Phone Number**
Email Address	**Physical Address**

Are copies of the legal papers available? ☐ **Yes** ☐ **No**

Select Type (2)

☐ **Conservator** ☐ **Durable POA** ☐ **Healthcare POA** ☐ **Representative Payee**

☐ **Paid Advocate** ☐ **Patient Advocate** ☐ **Guardian (Private/Family)** ☐ **Guardian (Public/Corporate)**

☐ **Other (e.g. family member who does not have legal status)**

If other, describe relationship:

Name	**Phone Number**
Email Address	**Physical Address**

Are copies of the legal papers available? ☐ **Yes** ☐ **No**

Other Comments:

Transition Planning Team and Support Network:			
Transition Planning Team:			
Who will be included in transition planning? (May include but is not limited to: family members, friends, facility social worker, options counselor, managed care agency staff, home and community-based waiver staff, Independent Living counselor, children's services, behavioral health and developmental disabilities professionals, etc.). Update the list as necessary over the course of the transition process.			
Name	**Relationship / Role to Participant**	**Contact Phone and Email Address**	**Role in Transition Planning Process**

Transition Planning Team and Support Network:			
Support Network: Primary Backup Unpaid Supports			
Who are the primary support individuals when CAP/DA or PACE services are not available (i.e., backup unpaid supports)?			
Name	**Relationship**	**Contact Phone**	**Email Address**
Name	**Relationship**	**Contact Phone**	**Email Address**
Name	**Relationship**	**Contact Phone**	**Email Address**
What is the backup plan if primary supports are unavailable (e.g., 24-hour care is needed)?			
If there are no identified supports, what is being done to develop them? (e.g. referral to Centers for Independent Living, linking to social/cultural clubs, linking to faith community).			
What role will transition team members, or others, have in helping to develop supports?			

Transition Planning Team and Support Network:

Support Network: Other Unpaid Supports

Who does the participant have as a support system of unpaid individuals? (e.g. friends, family, neighbors, faith community, services groups, civic organizations, etc. that can be called upon in times of distress [e.g. staff does not show, need unplanned assistance overnight, etc.])

Name	Relationship	Contact Phone and Email Address	Involved in planning?	Willing to help with hands-on care?
			☐ Yes ☐ No	☐ Yes ☐ No

How will this individual be involved?

Name	Relationship	Contact Phone and Email Address	Involved in planning?	Willing to help with hands-on care?
			☐ Yes ☐ No	☐ Yes ☐ No

How will this individual be involved?

Name	Relationship	Contact Phone and Email Address	Involved in planning?	Willing to help with hands-on care?
			☐ Yes ☐ No	☐ Yes ☐ No

How will this individual be involved?

Transition Planning Team and Support Network:
Support Network: Social Connections
Who in addition to those individuals identified in Primary and Other Unpaid Support Systems does the participant have as a community-based social connection?
Does the participant have people in the community that they want to reconnect with upon returning home? ☐ Yes ☐ No Please explain
How does the participant want friends and/or family to participate in supports?
Are there other family-specific, friend-specific or community-specific items that need to be considered?
Other Comments:

Transition Planning Team and Support Network:
Support Network: Caregivers
Does the participant want help in selecting the staff to work with him/her? ☐ Yes ☐ No Explain:
What special considerations should be made in ensuring support staff meet the needs of the participant? (e.g., is training needed? If training is needed how will the training be conducted and when? Does the participant want the support staff to do or not do specific things, etc.)?
Will there be a paid live-in caregiver? ☐ Yes ☐ No
Has the paid caregiver received in-facility training with facility staff prior to the transition? ☐ Yes ☐ No If yes, describe training received (e.g. wound cleaning, medication administration, injection, etc.):
Will there be an unpaid live-in caregiver? ☐ Yes ☐ No
Has the unpaid caregiver received in-facility training with facility staff prior to the transition? ☐ Yes ☐ No If yes, describe training received (e.g. wound cleaning, medication administration, injection, etc.):

Income and Other Benefits:

Medicare

Does the Participant have Medicare? ☐ Yes ☐ No **Medicare Number:**

If yes, please check all that apply:

☐ Medicare A ☐ Medicare B (if checked, see below) ☐ Medicare C ☐ Medicare D

Part B Premium Amount:

Is this premium deducted from the participant's Social Security benefits? ☐ Yes ☐ No

Veteran's Benefits

Is the participant a veteran? ☐ Yes ☐ No

Is the participant a spouse of a veteran? ☐ Yes ☐ No

If yes to either question, has the participant applied for benefits? ☐ Yes ☐ No

Benefits from the Veterans Administration **Monthly Amount:**

☐ Yes ☐ No ☐ Has Not Applied ☐ Application Submitted

☐ Denied, In Appeal ☐ Denied, Not Appealed ☐ N/A

If the participant is eligible and answered "No" and no application was submitted, explain

Income and Other Benefits:
Social Security Income
Social Security Survivor Benefit (e.g. spouse, former spouse or parent) ☐ Yes ☐ No
Name of other source/individual (Note: SSN of other individual will be needed)
Relationship of other source/individual to the participant
Supplemental Security Income (SSI)? **Monthly Amount:** ☐ Yes ☐ No ☐ Has Not Applied ☐ Application Submitted ☐ Denied, In Appeal ☐ Denied, Not Appealed ☐ N/A
If the participant is eligible and answered "No" and no application was submitted, explain

Income and Other Benefits:	
Social Security Disability Income	
Social Security Disability Insurance (SSDI)	**Monthly Amount:**
☐ Yes ☐ No ☐ Has Not Applied ☐ Application Submitted	
☐ Denied, In Appeal ☐ Denied, Not Appealed ☐ N/A	
If the participant is eligible and answered "No" and no application was submitted, explain	

Income and Other Benefits:
Social Security Award Letter
Has a social security income letter been requested? **Important: obtain social security award letter as early as possible in the transition planning process. May need to be requested more than once.** ☐ Yes ☐ No Date Obtained: Amount Confirmed: Comments:

Income and Other Benefits:	
Other Source of Income	
(Indicate any other sources of income below)	
Other Source of Income (describe):	**Monthly Amount:**
Other Source of Income (describe):	**Monthly Amount:**
Other Source of Income (describe):	**Monthly Amount:**

Income Verification
☐ **Check here if the participant has no income from any source**
Total Monthly Income: **(Please indicate the sources of monthly income below)** **Note: If total monthly income is outside the Medicaid Income Limits a Deductible may apply.**

Income and Other Benefits:
Access to Income
Does the participant have a bank account? ☐ Yes ☐ No ☐ N/A If no, where does the participant want to bank, and what is the plan to set up a bank account for the participant? If N/A, explain:
Is the facility the Representative Payee? ☐ Yes ☐ No ☐ N/A If yes, what is the plan for ensuring the benefits transfer from the facility to the participant or other identified Representative Payee? If N/A, explain:

Income and Other Benefits:	
DSS Eligibility Verification	
Has the participant been linked with DSS Medicaid worker? ☐ Yes ☐ No	
Medicaid Worker Name:	**Medicaid Worker Phone Number/Email Address:**
Has the participant been had Long-Term Care Medicaid confirmed with DSS Medicaid worker? ☐ Yes ☐ No If no, please explain:	
Has the participant discussed Income and potential Medicaid Deductible with DSS Medicaid worker? ☐ Yes ☐ No If no, please explain:	
Were you (as the TC) a part of the initial (or any) conversations held with the DSS Medicaid Worker? ☐ Yes ☐ No Date: If no, explain:	

Income and Other Benefits:
Other Benefits
Has the participant applied for Supplemental Nutrition Assistance Program (SNAP) benefits? ☐ Yes ☐ No ☐ N/A If no, what is the plan to apply for SNAP benefits? If N/A, explain:
What other non-Medicaid benefits or services does the participant need and what is the plan to explore these? (e.g. SNAP-Related Benefits, DVR-Independent Living Programs, Deaf-Blind Benefits, Vocational Benefits, etc.)

Income and Other Benefits:
Deductible
Has the participant received a Spend Down worksheet from the DSS? ☐ Yes ☐ No Comments:
Has the participant received an Explanation of Expenditures handout from the DSS? ☐ Yes ☐ No Comments:
Does the participant desire to move forward with transitioning with a Medicaid deductible? ☐ Yes ☐ No ☐ N/A (No deductible) If No, what other options have been discussed and what action is being taken?

Credit History
How does the participant describe his or her credit history and/or concerns (including any money owed)? (e.g. unpaid rent, default on loan(s), bankruptcy, unpaid utility expenses, etc.)
Has a credit report been requested? ☐ Yes ☐ No **Credit Reporting Agency Name:** **Date Requested:** **Are there credit items listed on the report that need to be addressed?** ☐ Yes ☐ No **If yes, what are those items?**
If there are identified credit concerns, what is being done to address them?

Criminal History
Has the participant ever been arrested? ☐ Yes ☐ No If yes, explain:
Does the participant have an outstanding arrest warrant? ☐ Yes ☐ No If yes, explain:
Does the participant have any pending charges? ☐ Yes ☐ No If yes, explain:
Has the participant ever been convicted of a crime? ☐ Yes ☐ No If yes, explain:
If the participant was convicted of a crime, have all the terms of the sentence been fulfilled? ☐ Yes ☐ No If no, explain:
Has the participant ever violated a condition of parole or probation? ☐ Yes ☐ No If yes, explain:
Has the participant ever been incarcerated for more than 1 year? ☐ Yes ☐ No If yes, when:
Has participant been provided expungement resources? https://www.nccourts.gov/help-topics/court-records/expunctions ☐ Yes ☐ No ☐ N/A If yes, what is the status?

Desired Living Arrangement	
From the participant's perspective, what is the desired living arrangement? (please include items such as county, city vs. rural, with family/friends or without, specific amenities, access to transportation, access to specific social or community activities, etc.):	**From the other's perspectives, what do you know about the Participant's desired living arrangement?** (please include items such as county, city vs. rural, with family/friends or without, specific amenities, access to transportation, access to specific social or community activities, etc.):
From the participant's perspective, what is needed to feel safe in the community? (this could include security features in the home, people or influences the Participant does not want to be around, routines, etc.) Please describe:	**From the other's perspective, what is needed for the Participant to feel safe in the community?** (this could include security features in the home, people or influences the Participant does not want to be around, routines, etc.) Please describe:
What is the plan to accommodate as many of these items as possible? (if it is not possible to accommodate the desires, please explain why, and what alternatives are being considered?)	

Housing:

Pre-Admission Living Arrangement

Prior community-based living arrangement preceding admission(s)

(within *5 years* preceding admission to institutional care) Select all that apply:

- ☐ Home Owned by Participant
- ☐ Home Owned by Family Member
- ☐ Home Owned by Friend / Significant Other
- ☐ Apartment Leased by Participant
- ☐ Apartment Leased by Family Member
- ☐ Apartment Leased by Friend/Significant Other
- ☐ N/A Residing in institutional care greater than 5 years
- ☐ Camper/Trailer Owned by Participant
- ☐ Camper/Trailer Owned by Family Member
- ☐ Camper/Trailer Owned by Friend / Significant Other
- ☐ Assisted Family Living (AFL)
- ☐ Group Home
- ☐ Department of Corrections Facility
- ☐ Homeless/Homeless Shelter
- ☐ Other community based setting (List Explain:

Does the participant have housing to return to after discharge? ☐ Yes ☐ No

Will the participant be doing a home stay before transitioning? ☐ Yes ☐ No

If yes, please describe plan:

Housing:			
Post-Discharge Living Arrangement Availability			
If the participant has housing to return to after discharge, please provide the information below.			
Address	**City**	**State**	**ZIP**

Type of Home:

- ☐ Home Owned by Participant
- ☐ Home Owned by Family Member
- ☐ Home Owned by Friend / Significant Other
- ☐ Apartment Leased by Participant
- ☐ Apartment Leased by Family Member
- ☐ Apartment Leased by Friend / Significant Other's
- ☐ Camper/Trailer Owned by Participant
- ☐ Camper/Trailer Owned by Family Member
- ☐ Camper/Trailer Owned by Friend / Significant Other
- ☐ Other community-based setting
- List/Explain:

Will the participant live with family? ☐ Yes ☐ No

Return Housing: Is rent/mortgage current? ☐ Yes ☐ No ☐ N/A	**Amount of Rent/Mortgage:**
How is rent/mortgage currently paid?	**How will rent/mortgage be paid upon discharge?**

Comments:

Housing:

Living Arrangement to be Identified

What is the desired county of residence?

Is the participant open to other counties? ☐ Yes ☐ No

If yes, list additional counties:

Does the participant have a preferred housing arrangement upon transition?

☐ Yes ☐ No If yes, please select preference below:

☐ Home Owned by Participant
☐ Home Owned by Family Member
☐ Home Owned by Friend / Significant Other
☐ Apartment Leased by Participant
☐ Apartment Leased by Family Member
☐ Apartment Leased by Friend / Significant Other
☐ Camper/Trailer Owned by Participant
☐ Camper/Trailer Owned by Family Member
☐ Camper/Trailer Owned by Friend / Significant Other
☐ Other community-based setting

List/Explain:

Does the participant have a Section 8 voucher? ☐ Yes ☐ No

If yes, what is the status of the voucher?

If no, has an application been submitted? ☐ Yes ☐ No

If an application has not been submitted, is the desired destination accepting Section 8 applications? ☐ Yes ☐ No

Comments:

Does the participant have a voucher for public housing? ☐ Yes ☐ No

If yes, what is the status of the voucher?

If no, has an application been submitted? ☐ Yes ☐ No

If an application has not been submitted, does the desired destination accept public housing applications? ☐ Yes ☐ No

Comments:

Has a referral been made to the Targeted/Key Program?

☐ Yes ☐ No If yes, date:

If yes, how many units is the participant on a waiting list for?

If no, explain:

Note: Attach Targeted/Key program application and waitlist confirmation email to this Readiness Tool.

Housing:

Potential Barriers

Does the participant have tenancy concerns that will make obtaining housing difficult?

- ☐ No income
- ☐ Owe money to housing authority
- ☐ Previously evicted from subsidized housing
- ☐ Previously evicted from non-subsidized housing
- ☐ Owe money to utility company
- ☐ Criminal Record
- ☐ Registered Sex Offender
- ☐ Smoking
- ☐ Requires housing be on the first floor
- ☐ Other, please explain:

Will the participant need to consider a live-in support (paid or unpaid) when searching for housing?

☐ Yes ☐ No Comments:

If yes, is this individual going to be on the lease? ☐ Yes ☐ No ☐ N/A (no lease required)

Has credit and criminal history of live-in support (paid or unpaid) been vetted?

☐ Yes ☐ No Comments:

Will a Reasonable Accommodation letter be needed? ☐ Yes ☐ No

Comments:

Housing:
Participant Engagement in the Process
How is the participant engaged in the housing process? (check all that apply) ☐ Completing applications ☐ Actively resolving past credit concerns ☐ Obtaining necessary financial info ☐ Following up with properties ☐ Providing properties with required identification documents ☐ N/A (e.g. have a home already) ☐ Other:
Has the participant been actively viewing housing options? ☐ Yes ☐ No ☐ N/A
Will the participant view the secured housing unit prior to lease signing? ☐ Yes ☐ No ☐ N/A
If Yes, how will the participant view the housing unit? (e.g. in-person, online viewing, by video)
If No, provide explanation (e.g. not medically stable, lack of transportation)
Comments:

Housing:				
Other Waitlisted Properties				
Property Name	**Address**	**Contact Person**	**Date Added**	**Status / Comments**

Housing:				
Other options pursued				
(e.g., property managers, private homeowners, etc.)				
Property Name	**Address**	**Contact Person**	**Date(s) Contacted**	**Status / Comments**

Housing:
Modifications and Other Considerations
Does the participant need any physical changes or home modification to help them live in the community? ☐ Yes ☐ No **Has a referral been made to DVR/IL?** ☐ Yes ☐ No If modifications are needed, what are they? (e.g. ramp, grab bars, modified doorways, etc.)

Modification Needed

Does the participant need basic household safety items? (e.g. hoarding abatement, etc.)
Please list the items and the plan to secure them.

Safety Need	Plan
Smoke Detector	
Fire Extinguisher	
Electrical Wiring	
Pest Eradication	
Other	
Other	
Other	

Are there any other housing considerations? (e.g. repairs, deep cleaning, other)

What does the participant need to feel safe in the home?

How will the participant get out of their home in case of a fire?

How will the participant get out of the home for personal safety? (e.g. cases of domestic violence, home invasion, etc.)

Housing:				
Utility Needs				
What utilities are needed? (check all that apply) ☐ Water ☐ Electricity ☐ Gas ☐ Trash ☐ Internet ☐ Phone ☐ Other:				
Utility	**Is there an outstanding bill?**	**If there is an outstanding bill, has it been resolved?**	**Is a deposit needed?**	**Has the utility been secured?**
☐ Water	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No Comments:
☐ Electricity	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other:	☐ Yes ☐ No Comments:

			If No, explain:	
☐ Gas	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No Comments:
☐ Trash	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No Comments:
☐ Internet	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used?	☐ Yes ☐ No Comments:

		☐ Church / Private Organization ☐ Other: If No, explain:	☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	
☐ Landline Phone	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No Comments:
☐ Mobile Phone	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No Comments:

☐ Federally Funded Lifeline Services	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No Comments:
☐ Other:	☐ Yes ☐ No If yes, amount:	☐ Yes ☐ No If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No If yes, how much is the deposit? If yes, what resources were used? ☐ TYSR ☐ IL ☐ DSS ☐ Utility Provider ☐ Church / Private Organization ☐ Other: If No, explain:	☐ Yes ☐ No Comments:

Health & Wellness:		
Medical Health		
From the Participant's perspective, what medical conditions or concerns need to be addressed?		**From the other's perspectives, what medical conditions or concerns need to be addressed?**
Initial	**Did you obtain an *initial* copy of the current diagnosis from the facility chart (attach)?** ☐ Yes ☐ No If no, explain:	
	Did you obtain an initial copy of current medications from the facility chart (attach)? ☐ Yes ☐ No If no, explain:	
Final	**Did you obtain a *final* copy of the current diagnosis from the facility chart (attach)?** ☐ Yes ☐ No If no, explain:	
	Did you obtain a *final* copy of current medications from the facility chart (attach)? ☐ Yes ☐ No If no, explain:	

Health & Wellness:
Medical Health (Continued)
Observations based on RN Notes, Social Work Notes, Psych Notes, etc. identified during TC visit **Note to TC: Pay attention to elements that could reflect other's perspectives on the Participant (e.g., daily behavior and social interactions)** Example: Synthesis of compliance issues, undocumented issues
Does the current physician support discharge? ☐ Yes ☐ No Explain:

Health & Wellness:
Mental/Behavioral Health
Does the participant have any mental health diagnoses? ☐ Yes ☐ No
Does the participant have any behavioral health diagnoses? ☐ Yes ☐ No
Has a referral been made to the MCO? ☐ Yes ☐ No **Please explain:**
Please list any psychiatric hospitalizations
Describe any current or past behavioral/mental health treatments
Has the participant exhibited self-injurious behaviors in the last 90 days? (e.g. attempted suicide, made suicidal gestures, expressed suicidal ideation, reckless and puts self in dangerous situations) ☐ Yes ☐ No
Actions taken to address the issue(s).

Health & Wellness:
Mental/Behavioral Health (Continued)
Has the participant exhibited injurious behaviors to others in the last 90 days? (e.g. assaultive to other children or adults, attempts to or has sexually assaulted other individuals) ☐ Yes ☐ No
Actions taken to address the issue(s).
Has the participant experienced severe physical or sexual abuse or has s/he been exposed to extreme violent behavior in the past? (Subject to or witnessed extreme physical abuse, domestic violence or sexual abuse, severe bruising in unusual areas; forced to watch torture or sexual assault; witness to murder, etc.?) ☐ Yes ☐ No
Actions taken to address the issue(s).
Has the participant exhibited atypical behaviors in the last 90 days? (History or pattern of fire-setting; animal cruelty; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including side effects to medications); repetitive body motions (e.g. twirling, wringing hands, etc.) or vocalizations (e.g. echolalia); smears feces; etc.) ☐ Yes ☐ No
Actions taken to address the issue(s).

Health & Wellness:
Mental/Behavioral Health (Continued)
Has the participant had difficulties with social or environmental adjustments? (Change schedules, change environments, loud noises, crowds, strong smells, etc.?) ☐ Yes ☐ No
Actions taken to address the issue(s).
Has the participant had difficulties making and maintaining healthy relationships and/or social adjustments? (Unable to form positive relationships with peers; provokes and victimizes others; does not form bond with caregiver. Regularly involved in physical fights with others; verbally threatens people; damages possessions of self or other; runs away; steals; untruthful; mute; confined due to serious law violations; does not seem to feel guilt after misbehavior, etc.) ☐ Yes ☐ No
Actions taken to address the issue(s).
Has the participant had difficulties managing his/her feelings? (Severe temper; screams uncontrollably; cries inconsolably; withdrawn and uninvolved with others; regularly expresses strong emotions such as the feeling that others are out to get them; excessive preoccupation, etc.) ☐ Yes ☐ No
Actions taken to address the issue(s).
Does the participant own a firearm or other weapons? ☐ Yes ☐ No
If yes, what is the plan to secure the firearm or other weapons?
Any Additional Comments or Observations

Health & Wellness:
Substance Use
Does the participant have any Substance Use Diagnoses? ☐ Yes ☐ No If yes, describe:
Has the participant received services from a provider specializing in substance use services? ☐ Yes ☐ No If yes, describe:
Does the participant exhibit atypical behaviors in response to drug or alcohol use (e.g. hyper strength, aggression towards others, self-injurious, etc.)? ☐ Yes ☐ No If yes, describe: **Actions taken to address the issue(s):**
Does the participant need help connecting to community alcohol and/or drug treatment resources? ☐ Yes ☐ No If yes, explain what is being done to help the participant access these resources:
Has a referral been made to the LME/MCO? ☐ Yes ☐ No
Observations Example: Participant leaves facility frequently and returns exhibiting altered states behaviors. **Actions taken to address the issue(s):**

Functional, Independent, & Assistive Supports:			
Functional Support Needs (Activities of Daily Living – ADLs)			
Activity *(Please write in the appropriate boxes that apply)*	**Type of Support** 0 = None 1 = Monitoring (asking questions but not telling the person) 2 = Verbal/Gesture Prompting (giving a verbal or gestural/visual direction) 3 = Partial Physical Assistance (giving some help, but not full support) 4 = Full Physical Support (all, or nearly all, steps need to be done for the participant)	**Who is responsible?** (roles and responsibilities)	**Notes and Extenuating Circumstances to be Considered.**
Dressing	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Bathing	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Transferring	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Toileting	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Grooming	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Feeding / Eating	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Mobility	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		

Functional, Independent, & Assistive Supports:			
Independent Living Support Needs (Instrumental Activities of Daily Living - IADLs)			
Activity *(Please write in the appropriate boxes that apply)*	**Type of Support** 0 = None 1 = Monitoring (asking questions but not telling the person) 2 = Verbal/Gesture Prompting (giving a verbal or gestural/visual direction) 3 = Partial Physical Assistance (giving some help, but not full support) 4 = Full Physical Support (all, or nearly all, steps need to be done for the participant)	**Who is responsible?** (roles and responsibilities)	**Notes and Extenuating Circumstances to be Considered.**
Grocery Shopping / Meal Preparation	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Taking Medications	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Home Chores, Maintenance and Upkeep (e.g., home maintenance, upkeep, laundry, etc.)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Daily Decision Making (e.g., managing appointments / paying bills / money management / budgeting) Managing Appointments	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Community Interactions (e.g., interacting with community members / getting to and from places in the community / visiting friends & family / engaging in preferred activities Interacting with Community Members)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Comments/Observations:			

Functional, Independent, & Assistive Supports:		
DMEPOS & Assistive Technology Support Needs		
Are there any communication supports needed? ☐ Yes ☐ No If yes, please check all that apply:		
☐ Visual Support Needed ☐ Audio Support Needed ☐ Literacy Support Needed	☐ Language Support Needed ☐ Other Supports Needed (explain below)	
Explain:		
Does the participant need any Durable Medical Equipment (DME) Prosthetics, Orthotics, or Supplies (POS)? ☐ Yes ☐ No If yes, list:		
Equipment/Supplies Needed	Script Obtained	If Yes, Date of Script
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
Does the participant own any Adaptive Equipment/Assistive Technology? ☐ Yes ☐ No If yes, list:		
Equipment Description		

Functional, Independent, & Assistive Supports:

DMEPOS & Assistive Technology Support Needs (Continued)

Does the participant need any Adaptive Equipment/Assistive Technology?

☐ Yes ☐ No If yes, list:

Equipment/Supplies Needed	Script Obtained?	If Yes, Date of Script
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:
	☐ Yes ☐ No ☐ N/A	Date:

Will the participant be using home monitoring? (e.g., SimplyHome®, Rest Assured®, Lifeline®, etc.) ☐ Yes ☐ No

Explain:

If yes, what is the plan for addressing the need?

Note: Remember to consider the following types of supplies:

Diabetic supplies, Feeding tube care and equipment, Tracheotomy care and equipment, Gloves, Feminine hygiene products, Ostomy and ileostomy supplies, Wound care supplies, Incontinence supplies (e.g. bed pads, adult diapers), modified dishes, gait belts, communication devices, etc.

Notes and Plan to Secure Functional Needs, DMEPOS, and Assistive Technology Supports

(Include who will take the lead and roles and responsibilities of team members)

Transportation	
How will the Participant get to community-based activities, appointments, or other destinations of choice?	
Does the participant need accessible transportation? (e.g. lift, wheelchair accessible van, stretcher transportation, etc.) ☐ Yes ☐ No Describe:	
Has the participant been linked with the county-specific Medicaid-funded transportation system? ☐ Yes ☐ No If no, explain:	
Public Transportation	**Will the participant need public transportation?** ☐ Yes ☐ No
	Is public transportation available? ☐ Yes ☐ No
	Does the participant know how to access local public transportation? (e.g. aware of local bus routes, bus stops, Uber/Lyft, etc.) ☐ Yes ☐ No If no, what is being provided to acquaint the participant with options?
	Has the participant applied to receive discounted tickets or taxi rides? ☐ Yes ☐ No If no, what is being provided to acquaint the participant with options?
	Does the participant know how to use public transportation? (e.g. able to enter bus, provide payment, use phone apps) ☐ Yes ☐ No If no, what is being provided to educate the participant?

Transportation (Continued)	
Medicaid-Funded Transportation	**Will the participant need Medicaid-Funded transportation?** ☐ Yes ☐ No
	Does the participant know how to access local Medicaid-Funded transportation? (e.g. phone number, website, contact agency) ☐ Yes ☐ No If no, what is being provided to acquaint the participant with options?
	Does the participant know how to use Medicaid-funded transportation? (e.g. know when to call, how much notice is needed, etc.) ☐ Yes ☐ No If no, what is being provided to acquaint the participant with options?
Block Grant Transportation	**Will the participant need a referral to the Division of Adult and Aging Services (DAAS) or local Area Agency on Aging (AAA) for Block Grant transportation?** ☐ Yes ☐ No
	If a referral was made, what is the status?
Other Transportation	**What other transportation has been explored to supplement Public, Medicaid-Funded, and Block-Grant Funded options?**

Rituals, Routines, Community Engagement, and Integration
How will the participant spend their day in a way that provides the support, social opportunity, and structure that is wanted and needed? Please describe (include things like waking up, going to bed, eating, bathing, exercise, watching TV, talking to friends/family, hobbies, going out, etc.):
Are there any rituals or routines that should be ensured for the Participant's health or well-being? Please describe:
What kinds of things are of interest to the Participant? (include hobbies, specific people or places, subject areas, activities, etc.):
Who does the participant know that is already connected to any of these areas?
What is the plan to ensure that as many of these items are incorporated into the Participant's life once home?

Employment, Volunteering, and Education	
Did the participant work prior to acquiring the disability? ☐ Yes ☐ No If yes, please describe the work previously held	
Is the participant interested in employment post-transition? ☐ Yes ☐ No If yes, please describe the type of employment the participant is interested in pursuing	
What kinds of employment are of interest to the Participant?	
Are there any volunteering interests the Participant wants to explore?	
What is the participant's highest level of education?	
☐ No formal schooling ☐ Less than grade 12 ☐ High school diploma ☐ GED or equivalent ☐ Some college ☐ Associate degree: occupational, technical or vocational program	☐ Associate degree: academic program ☐ Bachelor's degree ☐ Master's degree ☐ Professional school degree / Doctoral degree ☐ Does not know
Is the participant interested in pursuing education opportunities post-transition? ☐ Yes ☐ No	
Comments:	

Transition Funding Resources			
Item	**Justification**	**Amount**	**Source**

SAMPLE FOR RFP

Final Community-Based Plans:
Who Do I Call?
Case Manager Name: Phone #: Email Address: When to contact:
Home Health Provider Name: Phone #: Email Address: When to contact:
Home Health Provider Name: Phone #: Email Address: When to contact:
Backup Unpaid Support #1 Name: Relationship to participant: Phone #: Email Address: When to contact:
Backup Unpaid Support #1 Name: Relationship to participant: Phone #: Email Address: When to contact:
Other Community-Based Contact Name: Relationship to participant: Phone #: Email Address: When to contact:

Final Community-Based Plans:
Who Do I Call?
Housing Property Manager: Phone #: Email Address: When to contact:
Water: Phone #: Email Address: When to contact:
Electricity: Phone #: Email Address: When to contact:
Gas: Phone #: Email Address: When to contact:
Trash: Phone #: Email Address: When to contact:
Internet: Phone #: Email Address: When to contact:
Landline Phone: Phone #: Email Address: When to contact:

Final Community-Based Plans:
Who Do I Call?
Mobile Phone: Phone #: Email Address: When to contact:
Lifeline Services: Phone #: Email Address: When to contact:
Other: Phone #: Email Address: When to contact:
Other: Phone #: Email Address: When to contact:
Other: Phone #: Email Address: When to contact:

Final Community-Based Plans:		
Medical and Physical Health Supports		
Primary Care Doctor	**Name**	
	Organization/Practice Name	
	Initial Appointment Date and Time:	
	Phone	**Email**
Specialist Doctor Type:	**Name**	
	Organization/Practice Name	
	Initial Appointment Date and Time:	
	Phone	**Email**
Specialist Doctor Type:	**Name**	
	Organization/Practice Name	
	Initial Appointment Date and Time:	
	Phone	**Email**
Dentist	**Name**	
	Organization/Practice Name	
	Initial Appointment Date and Time:	
	Phone	**Email**
Pharmacy	**Name**	
	Address	
	Phone	**Email**
Specialty Pharmacy	**Name**	
	Address	
	Phone	**Email**
Other Type:	**Name**	
	Organization/Practice Name	
	Phone	**Email**

Final Community-Based Plans:		
Mental Health and Behavioral Health Supports		
Community-Based Mental Health Professional	**Name**	
	Organization/Practice Name	
	Initial Appointment Date and Time:	
	Phone	**Email**
Community-Based Behavioral Health Professional	**Name**	
	Organization/Practice Name	
	Initial Appointment Date and Time:	
	Phone	**Email**
Community-Based Substance Use Health Professional	**Name**	
	Organization/Practice Name	
	Initial Appointment Date and Time:	
	Phone	**Email**
Other Type:	**Name**	
	Organization/Practice Name	
	Phone	**Email**

Final Community-Based Plans:			
Housing			
Will the participant live with anyone? ☐ Yes ☐ No			
If yes, who are the individuals (name and relationship to participant):			
Name	**Relationship**	**Phone #**	**Email**
Address:			
Phone #:			
Is the participant signing a lease? ☐ Yes ☐ No		**If yes, Date Lease Signed**	
Property Name		**Property Contact** Name: Phone #: Email:	
Housing Attestation Completed? ☐ Yes ☐ No **Date:**			
Housing Modifications Completed? ☐ Yes ☐ No Comments:			

Final Community-Based Plans:				
Functional Needs, DMEPOS, & Assistive Technology Supports				
Who should be contacted if there are equipment/supplies issues?				
Equipment Type:	**Name:**	**Address:**	**Phone:**	**Email:**

Final Community-Based Plans:		
Transportation		
Transportation Type	**Primary Transportation Source** **Name, phone, email**	**Secondary Transportation Source** **Name, phone, email**
Medical Appointments / Pharmacy		
Errands / Pay bills / Shopping		
Employment / Job		
Entertainment / Social Activities / Recreation / Physical fitness facility		
Government program offices (DSS, Social Security Office, DMV, etc.)		
Other		
Other		
Notes		

Final Community-Based Plans:	
Risk Mitigation	
The potential risk/issue: Staffing: Paid or unpaid staff not showing up as scheduled (This risk mitigation item is required for all transitions)	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:
The potential risk/issue: Housing: Including compliance with apartment rules and lease requirements such as smoking and visitors, and feeling safe) (This risk mitigation item is required for all transitions)	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:
The potential risk/issue: Medical Care: Accessing medical care including care from providers and transportation.	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:

Final Community-Based Plans:	
Risk Mitigation	
The potential risk/issue: Chronic Conditions: Includes wound care, managing diabetes, etc.)	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:
The potential risk/issue: Medications: Including remembering to take medication, picking up prescriptions, side effects, etc.	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:
The potential risk/issue: Adaptive Equipment: Including noting when something is wrong with the equipment, who to contact if the equipment has issues, understanding how to use equipment, etc.	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:

Final Community-Based Plans:	
Risk Mitigation	
The potential risk/issue: Mental Health Supports: Includes accessing proper mental health supports, keeping appointments, etc. (this is required for anyone who will be receiving mental health supports in the community)	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:
The potential risk/issue: Substance Use: Including accessing proper substance use supports, keeping appointments, etc. (this is required for anyone who will be receiving substance use supports in the community)	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:
The potential risk/issue: (items to consider include if natural supports become worn out, if there is a need for more paid services, if a provider discontinues services, if there is a medical emergency, if there are family dynamics that affect the Participant, transportation, preventing isolation, money management, other person-specific contingency plans, etc.)	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:

The potential risk/issue:	The plan to prevent/minimize this risk/issue from occurring:
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:

SAMPLE FOR RFP

Final Community-Based Plans:	
Risk Mitigation	
The potential risk/issue:	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:
The potential risk/issue:	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:
The potential risk/issue:	**The plan to prevent/minimize this risk/issue from occurring:**
	If the plan falls through, the backup strategy is:
	Applicable backup contact information:
	Risk if not addressed:

Final Checklist
Transition Date:
Date of Final Transition Planning Team Meeting:
Attendees at Final Transition Planning Team Meeting
Date of Pre-Transition Briefing:
Attendees at Pre-Transition Briefing
Is the Transition a Standard or High-Engagement? ☐ Standard ☐ High-Engagement
If the Transition is High-Engagement, what is the reason? ☐ Adverse Reports from the SNF within the last six months (e.g., substance use, non-adherence to policies, medication administration, physical and verbal abuse towards providers and natural supports, self-neglect, etc.) ☐ Adverse Reports from other transition team members during the transition process relating to the content above ☐ HCBS Assessment outlining post-transition risks that are not completely addressed prior to transition ☐ Any treatment Participant was involved in but did not complete prior to admission to the SNF ☐ Other (Describe):
Final housing type upon transition: ☐ Home Owned by Participant ☐ Home Owned by Family Member ☐ Home Owned by Friend / Significant Other ☐ Apartment Leased by Participant ☐ Apartment Leased by Family Member ☐ Apartment Leased by Friend/Significant Other ☐ Camper/Trailer Owned by Participant ☐ Camper/Trailer Owned by Family Member ☐ Camper/Trailer Owned by Friend / Significant Other ☐ Other community-based setting Explain:
If participant sought housing, select the housing source: ☐ Targeted Housing ☐ Section 8 ☐ Public Housing (not Section 8) ☐ Found Independently

Final Checklist (Continued)	
Date of Transition:	
Participant's Address Transitioned To:	
Final County of Residence:	Will this result in a change of Medicaid County? ☐ Yes ☐ No
Participant's Phone #:	Email Address:
Who was at the facility on Transition Day? ☐ TC ☐ Other If Other, explain:	
Who was at the participant's home on Transition Day? ☐ TC ☐ Other If Other, explain:	
Type of home and community-based service (HCBS) participant enrolled in upon transition: ☐ CAP DA ☐ PACE ☐ TBI	
Is the participant self-directed? ☐ Yes ☐ No	
Will there be a delay in services upon transition? ☐ Yes ☐ No If yes, explain:	
Post Transition Case Management Agency: Choose an item.	
Post Transition Case Management Agency Contact Person: Post Transition Case Management Agency Contact Email:	
Agency Phone Number:	
Date Final Readiness Tool and Plan Documents Submitted to MFP:	
Transition Coordinator Signature	Date
Supervisor Signature	Date

Signatures and Commitments
To Be Signed BEFORE the Transition Occurs

By signing below I am confirming the following:

- I received a completed copy of the MFP Transition Readiness Tool
- I am agreeing to the decisions that have been made through the planning process, including those documented in this MFP Transition Readiness Tool
- I understand that issues with my services, supports, and/or lifestyle may affect my ability to remain in the MFP program
- I understand that issues with my services, supports, and /or lifestyle may result in reinstitutionalization

Signature of MFP Participant: 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 required transition documents as required by the contract.

Signature of Transition Coordinator: Date:

Date Preliminary Plan Submitted to MFP:

Date Final Plan Submitted to MFP: