

MFP Transition Plan Readiness Tool

Effective June 26,2025

Total Questions : 96

Member Details :

Name:

Altruista ID:

Date Of Birth:

Home Phone:

1 PERSONAL INFORMATION AND TRANSITION TEAM CONTACTS

SECTION 1:

2 Participant's Name

Enter name here.

3 Participant's Phone Number

Enter phone number here.

4 Participant's Email

Enter email here.

5 Pre-Transition Medicaid County

Enter pre-transition county name here.

6 Post-Transition Medicaid County

Enter post-transition county name here.

7 Representative's Name (Guardian/POA) (if applicable)

Enter name here.

8 Representative Type

- ☐ Guardian of Self
- ☐ Guardian
- ☐ POA
- ☐ Other

9 Representative's Relationship

Enter relationship here.

10 Representative's Phone Number

Enter phone number here.

11 Representative's Email

Enter email here.

12 Guardianship/POA Document Obtained?

- ☐ Yes
- ☐ No
- ☐ N/A

13 MFP Transition Coordinator's Name

Enter name here.

14 MFP TC's Phone Number

Enter phone number here.

15 MFP TC's Email

Enter email here.

16 Facility Name

Enter facility name here.

17 Facility Social Worker's Name

Enter name here.

18 Facility Social Worker's Phone Number

Enter phone number here.

19 Facility Social Worker's Email

Enter email here.

20 What is the anticipated discharge date?

Select date.

21 Date MFP Consent Completed

Select date.

22 Date Copy of Consent Sent to Department

Select date.

23 HISTORY AND DESIRED FUTURE

SECTION II:

24 What brought you to the Facility in the first place?

Enter details here.

25 What was your life like before going into the facility? (e.g., who did you live with, were there specific interactions or relationships with others in the neighborhood, were there things that you used to do that they liked doing, did you have special routines or rituals that you engaged in, etc.)

Enter details here.

26 What are you looking forward to once you are in your home in the community? (e.g., hosting people in the home, going shopping, going to a faith-based institution, taking classes, etc.). What interests do you have that you want to explore once in the community? Is there something they can do while in the facility?

Enter details here.

27 INFORMAL UNPAID SUPPORTS

SECTION III:

28 What support will you need once in the community? (e.g., can you transfer, can your caregiver provide hands-on care with bathing, using the toilet, or transferring, how will you get around your home (independent or with assistance), how will you get around your community, etc.?)

☐

Initial Plan and Who will take the lead

Enter details here.

☐

Finalized Plan and Contact Information

Enter details here.

29 Who will provide the supports identified above outside of supports covered under waiver or PACEServices, and what will the individuals do? (e.g., sister will be responsible for bathing and personal hygiene needs when the In-Home Aide is not present, the cousin will be responsible for driving to the grocery and entertainment events, spouse will be responsible for meal preparation, laundry and housekeeping when In-Home Aide is not present, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

30 What is the plan (if any) for a trial homestay before completing the transition?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

31 What is the plan for pre-transition visits and training staff (ensure caregivers meet participant prior to providing care)?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

32 What is the plan if 24/7 supervision is needed?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

33 FINANCES AND NON-MEDICAID BENEFITS

SECTION IV:

34 What is the plan to support your financial needs? (e.g., where will you bank, do you need help with financial planning or budgeting, will there be a change in representative payee, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

35 Will you likely have a Medicaid Deductible?

☐ Yes

☐ No

36 If you choose to transition with a deductible, what is the plan to prepare and manage? (e.g., contact the DSS for a budgeting spreadsheet, identify expenses that can be applied to a deductible, who will be able to assist financially with other expenses, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

37 What is the plan for securing non-Medicaid Benefits? (e.g., Food Stamps, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

38 What is the plan for managing a county-to-county transfer (if applicable)?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

39 HOUSING AND LIVING ARRANGEMENTS

SECTION V:

40 What is your desired housing and living arrangement? (e.g., rural, urban, near shopping, with family, living alone, rent apartment, rent house, own, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

41 What documents are needed to secure housing and what is the plan to secure documents? (e.g., birth certificate, social security card, state issued ID, use of Supplemental Services Funding, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

42 Participant needs linkage to targeted housing and other options.

☐ Yes

☐ No

43 What is the plan to explore housing options other than targeted housing?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

44 What modifications or accessibility needs are necessary prior to the transition and what is the plan to secure them? (e.g., ramps, grab bars, hallways/doors widened, cabinets/counters lowered, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

45 What modifications or accessibility items are needed, but can wait until post-transition? What is the plan to secure them post-transition?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

46 What housing related needs will Supplemental Services Funds be used and what is the plan for securing the items? (e.g., deposits or past-due payments, application fees, modifications, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

47 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLY (DME/POS) NEEDS

SECTION VI:

48 What DME/POS is needed? (e.g., major equipment needs such as hospital beds, Hoyer lifts, ramps, independence aids such as grabbers, jar openers, sock aids, incontinence needs, modified dishes, gait belts, weighted utensils, lift recliners, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

49 What is the plan for securing essential DME/POS prior to transition? (must secure pre-transition)

- ☐ Initial Plan and Who will take the lead

Enter details here.

- ☐ Finalized Plan and Contact Information

Enter details here.

50 What is the plan for securing needed DME/POS post-transition? (can secure post-transition)

- ☐ Initial Plan and Who will take the lead

Enter details here.

- ☐ Finalized Plan and Contact Information

Enter details here.

51 What DME/POS or major medical equipment is essential prior to transition?

- ☐ Initial Plan and Who will take the lead

Enter details here.

- ☐ Finalized Plan and Contact Information

Enter details here.

52 What is the plan for use of In-Home Monitoring (Personal Emergency Response System)?

- ☐ Initial Plan and Who will take the lead

Enter details here.

- ☐ Finalized Plan and Contact Information

Enter details here.

53 PROVIDER SUPPORTS

SECTION VII:

54 What kinds of community providers are needed in the community? (e.g., primary care physician, specialists, dentist, pharmacist, mental health, behavioral health, etc.)

- ☐ Initial Plan and Who will take the lead

Enter details here.

- ☐ Finalized Plan and Contact Information

Enter details here.

55 What is the plan for establishing or linking the person to community providers?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

56 Date(s) of community provider appointments

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

57 MEDICATIONS

SECTION VIII:

58 What is the plan for ensuring the participant is able to manage medication post-transition?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

59 What is the discharge plan for managing medications and ensuring correct medications are dispensed as well as scripts obtained?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

60 What is the plan for any special medical training for informal supports? (feeding tube, transfers, medication, e.g.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

61 COMMUNITY INTEGRATION AND TRANSPORTATION

SECTION IX:

62 What is the plan to work for pay post-transition or for continuing education opportunities post-transition if desired? (EIPD referral if someone is interested in employment or education opportunities)

☐ Initial Plan and Who will take the lead

Enter details here.



Finalized Plan and Contact Information

Enter details here.

63 What established relationships exist in the desired community (e.g., family, friends, interests and hobby organization, communities of faith, etc.)?



Initial Plan and Who will take the lead

Enter details here.



Finalized Plan and Contact Information

Enter details here.

64 If they don't have established relationships in the desired community, what is the plan to develop them prior to transition, and continue to build them post-transition? (e.g., will someone be able to take the person to the community prior to transition and introduce them to the neighbors, will they be introduced to the local senior centers or other programs that are interested in, going to a rec center, joining the YMCA, is the person more introverted and does not want to have specific designed plans)



Initial Plan and Who will take the lead

Enter details here.



Finalized Plan and Contact Information

Enter details here.

65 What is the plan for getting around once in the community to non-medical activities?



Initial Plan and Who will take the lead

Enter details here.



Finalized Plan and Contact Information

Enter details here.

66 What is the plan for getting around to medical activities if they are not using Medicaid Transport?



Initial Plan and Who will take the lead

Enter details here.



Finalized Plan and Contact Information

Enter details here.

67 What is the plan for transition day (transportation and transport of personal items, food, transporting the medication from the facility to the home, etc.)?



Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

68 SAFETY AND ASSISTIVE TECHNOLOGIES

SECTION X:

69 What does the MFP participant need to feel safe?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

70 What is the plan for securing safety items? (e.g., smoke detectors, fire extinguishers, etc.)

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

71 What is the plan to get out of an emergency situation while in the home?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

72 What risk agreements exist (if any) and what is the MFP plan for mitigating the risks?

☐ Initial Plan and Who will take the lead

Enter details here.

☐ Finalized Plan and Contact Information

Enter details here.

73 FINAL CHECKLIST

SECTION XI:

74 Transition Date

Select date.

75 Participant's Address Transitioned To

Enter address here.

76 Type of Living Arrangement

☐ Home owned by beneficiary

- ☐ Home owned by family member
- ☐ Home owned by friend/significant other
- ☐ Apartment leased by beneficiary
- ☐ Apartment leased by family member
- ☐ Apartment leased by friend/significant other
- ☐ Camper/Trailer owned by beneficiary
- ☐ Camper/Trailer owned by family member
- ☐ Camper/Trailer owned by friend/significant other

77 Housing Source

- ☐ Targeted Housing
- ☐ Housing Choice Voucher (Section 8)
- ☐ Public Housing (not Section 8)
- ☐ Other Housing Subsidies (e.g., tax credit, etc.)
- ☐ Unsubsidized housing
- ☐ Not applicable (housing not sought)
- ☐ Other

Enter details here.

78 Lives with family

- ☐ Yes
- ☐ No

79 Program Choice:

- ☐ CAP/DA
- ☐ CAP/Choice
- ☐ PACE

80 CAP CME/PACE Entity Name

Enter name here.

81 CAP CME/PACE Contact Name

Enter name here.

82 CAP CME/PACE Contact Phone Number

Enter phone number here.

83 CAP CME/PACE Contact Email

Enter email here.

84 Who was at the facility on Transition Day?

Enter details here.

85 Who was at the participant's home on Transition Day?

Enter details here.

86 Date of Final Transition Planning Team Meeting

Select date.

87 Attendees at Final Transition Planning Team Meeting

Enter details here.

88 Date of Pre-Transition Briefing

Select date.

89 Attendees at Pre-Transition Briefing

Enter details here.

90 Is the transition Standard or High-Engagement?

- ☐ Standard
- ☐ High-Engagement

91 If the Transition is High-Engagement, what is the reason?

- ☐ Adverse report 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

Enter details here.

92 Date Final Plan Submitted to MFP

Select date.

93 MFP Transition Coordinator Signature

94 MFP Transition Coordinator Signature Date

Select date.

95 MFP Transition Manager's Signature

96 MFP Transition Manager's Signature Date

Select date.