**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.

It is important to note that this is NOT an assessment tool. It is intended to be a planning and communication tool.

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| **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 #:** | |

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| **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?** |

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| **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?** | |

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| **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 |  |

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| **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 MFP facility, 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: |

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| **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? |

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| **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 |  |  |

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| **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:** | |

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| **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** |
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| **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** |
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| **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?** | | | |

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| **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? | | | | |

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| **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:** |

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| **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.): |

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| **Income and Other Benefits:** |
| **Medicare** |

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| **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 |

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| 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 | |

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| **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 | |

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| **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 | |

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| **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: |

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| **Income and Other Benefits:** | |
| Other Sources 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:** |

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| 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.** |

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| **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: |

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| 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: | |

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| **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.) |

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| **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? |

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| 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?** |

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| 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? |

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| 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?) | |

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| **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’s  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: | |

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| **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:** | | | | | |

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| **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’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: |
| **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. | |

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| **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:** | |

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| **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  N/A (e.g. have a home already)  identification documents  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:** |

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

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| **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:  If No, explain: | Yes  No  Comments: |
| 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  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: |
| 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: |

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| **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: | |

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| **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: |

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| **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).** |

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| **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).** |

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| **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** |

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| **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):** |

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| **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 |  |  |

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| **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:** | | | |

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| **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 | | | |
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| **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) | | |

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| 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? |

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| **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?** |

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| 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?** |

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| 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: | |

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

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| **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: |

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| **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: |

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| **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** |

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| **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** |

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| **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** |
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| **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: | | | | |

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| **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:** |
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| **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** | | |

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| **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:** |

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| **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:** |

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| --- | --- |
| **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:** |

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| **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:** |

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| 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 | |

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| --- | --- |
| **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: