SHOW-ME HOME
A Money Follows the Person Program

ATTACHMENT F
TRANSITION PLAN

PARTICIPANT INFORMATION

LAST NAME, FIRST NAME		DATE OF BIRTH
PHONE		EMAIL
MEDICAID #	MFP APPROVAL DATE	DATE TRANSITION PLAN STARTED
ADDITIONAL COMMENTS REGARDING THE INDIVIDUAL THAT MAY BE PERTINENT		

SME CONTRACTOR INFORMATION

CONTRACTOR NAME	TRANSITION COORDINATOR NAME
TRANSITION COORDINATOR PHONE	TRANSITION COORDINATOR EMAIL
MFP REGIONAL COORDINATOR	REGION
ADDITIONAL COMMENTS REGARDING THE SME CONTRACTOR THAT MAY BE PERTINENT	

NURSING HOME INFORMATION

FACILITY NAME	FACILITY PHONE	DATE OF ADMISSION
ADDRESS		COUNTY
CONTACT PERSON	CONTACT PERSON PHONE	CONTACT PERSON EMAIL
ADDITIONAL COMMENTS REGARDING THE NURSING HOME THAT MAY BE PERTINENT		

COMMUNITY HOME ADDRESS

COMPLETE AFTER CHOICE OF COMMUNITY HOUSING HAS BEEN DETERMINED		
ADDRESS	COUNTY	PHONE

PERMISSION STATEMENT

I affirm I have met with the Transition Coordinator listed below and I have given my permission to my Transition Coordinator and their employing organization to assist me with transitioning from the above facility. We will develop a plan that shows my supports and goals to live in the community. I understand that changes can be made, and this Plan serves as a guide to help me with my transition. I also understand the Transition Coordinator and/or their employing organization is to provide me with information, supports, and resources that will help me make a successful transition to the community.

TRANSITION COORDINATOR NAME	TRANSITION ORGANIZATION NAME
PARTICIPANT SIGNATURE	DATE

CONTRACTOR ACTIONS

☐	Provide participant with MFP brochures/Pamphlets
☐	Complete this Transition Plan in its entirety with the Transition Team (participant, nursing home, family, doctor, legal representative, DSDS SME Regional Coordinator)
☐	Tour housing unit to identify any issues
☐	Complete the Emergency Plan in its entirety
☐	Send Transition Plan to the Regional Coordinator once complete

MEDICAL INFORMATION

Will your doctor continue to see you once you move into the community?		☐ Yes	☐ No
• If no, have you identified a doctor in the community who will accept you?		☐ Yes	☐ No
• If you have identified a doctor able to accept you once you move into the community, do you have an appointment within 2 weeks of transition?		☐ Yes	☐ No
Will your doctor prescribe a 30-day supply of medication?	☐ No Medications	☐ Yes	☐ No
Have you selected a pharmacy?	☐ No Medications	☐ Yes	☐ No
Does your pharmacy deliver medications to your home?	☐ No Medications	☐ Yes	☐ No

DOCTOR NAME	PHARMACY NAME
DOCTOR TELEPHONE	PHARMACY TELEPHONE
DOCTOR ADDRESS	PHARMACY ADDRESS

Has a referral ever been made due to concerns about your health, safety, or well-being?	☐ Yes	☐ No

IF YES, EXPLAIN IN DETAIL

MENTAL HEALTH NEEDS

Have you received mental health services or counseling in the past?		☐ Yes	☐ No
Would you like a referral to a mental health provider?		☐ Yes	☐ No
Are you taking medication/treatment requiring regular mental health follow-up visits?		☐ Yes	☐ No
Do you have a preference for a mental health provider	☐ N/A	☐ Yes	☐ No

IF YES, PROVIDER NAME	PROVIDER ADDRESS	PROVIDER PHONE

IF YES, DESCRIBE THE MENTAL HEALTH PLAN INCLUDING ELIGIBLE PROGRAMS, RESOURCES, AND SUPERVISION PHYSICIAN:

Do you have a history or alcoholism or drug abuse?	☐ Yes	☐ No

IF YES, EXPLAIN CIRCUMSTANCES

IF YES, EXPLAIN THE SUBSTANCE ABUSE PROGRAM INCLUDING COUNSELING/TREATMENT DATE AND TIMES

PERSONAL HEALTH NEEDS (Please attach Plan of Care)

Do you have your physician's approval for nursing home transition?	☐ Yes	☐ No
Do you need assistance with bathing?	☐ Yes	☐ No
IF YES: ☐ Bathing in the bathtub ☐ Bathing in the Bed ☐ Spongebath		
Do you need assistance with dressing?	☐ Yes	☐ No
IF YES: ☐ Lower extremities ☐ Upper extremities		
Do you need assistance with toileting?	☐ Yes	☐ No
IF YES: ☐ Getting on/off commode ☐ With pads		
Do you need assistance with bladder care?	☐ Yes	☐ No
IF YES: ☐ Catheter ☐ Urinal ☐ Other		
Do you need assistance with bowel care?	☐ Yes	☐ No
IF YES: ☐ Suppositories ☐ Laxatives ☐ Other		
Do you need assistance with eating?	☐ Yes	☐ No
IF YES: ☐ Feeding ☐ Setup ☐ Cutting Food ☐ Clean up ☐ Meal preparation		
Do you need assistance with housekeeping?	☐ Yes	☐ No
IF YES: ☐ Dusting ☐ Mopping ☐ Vacuuming ☐ General Cleaning ☐ Other		
Do you need assistance transferring from one place to another?	☐ Yes	☐ No
IF YES: ☐ Hoyer Lift ☐ Pivot Lift ☐ Staff to assist with equipment ☐ Other		

PROVIDE THE NAMES OF THREE (3) SUPPORTIVE FAMILY MEMBERS, FRIENDS, OR COMMUNITY ADVOCATES

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

ASSISTIVE TECHNOLOGY/DEVICES – *For additional assistance, call MOAT (800) 647-8557*

Do you currently use any assistive technology devices or Durable Medical Equipment?		☐ Yes	☐No
IF YES, DESCRIBE			
Do you need any assistive devices or Equipment to increase your independence?		☐ Yes	☐No
IF YES, DESCRIBE			
Are you interested in an Assistive Technology Assessment?		☐ Yes	☐No
If Assistive Technology or DME is required: have you ordered the equipment?	☐ N/A	☐ Yes	☐No
do you have a plan to pay for it?	☐ N/A	☐ Yes	☐No
do you need funding assistance?	☐ N/A	☐ Yes	☐No
Have you worked out delivery?	☐ N/A	☐ Yes	☐No
do you need training to use?	☐ N/A	☐ Yes	☐No

FURNISHINGS

Have you completed the attached transition checklist detailing what possessions you have and what possessions you will need to purchase before transition takes place?	☐ Yes	☐ No
Do you have money to buy additional wants and needs?	☐ Yes	☐ No
Are you aware of places which may donate furnishings?	☐ Yes	☐ No
Have you coordinated your move?	☐ Yes	☐ No
Do you need assistance moving?	☐ Yes	☐ No
Do you need assistance setting up your new home?	☐ Yes	☐ No

TRANSPORTATION

Are you able to take care of your transportation needs?	☐ Yes	☐ No
Do you need specialized transportation?	☐ Yes	☐ No
Do you know how to schedule appointments to use specialized transportation?	☐ Yes	☐ No

MEAL PLANNING

Do you need independent living skills training in this area?	☐ Yes	☐ No
Have you coordinated a plan so you can purchase, cook, and eat meals?	☐ Yes	☐ No
Do you have a special or complex diet regimen you must follow?	☐ Yes	☐ No
Who will do the initial shopping for groceries and supplies?	NAME/RELATIONSHIP	

SOCIAL AND LEISURE ACTIVITIES

Are you able to familiarize yourself with your new neighborhood?	☐ Yes	☐ No
Do you need assistance in meeting your new landlord and neighbors?	☐ Yes	☐ No
Do you need assistance in planning daily or weekly social activities?	☐ Yes	☐ No
Do you want skills training to assist you with any of these activities	☐ Yes	☐ No
What activities do you plan on doing to keep yourself busy once you return home?		

EMPLOYMENT/VOLUNTEERING

Are you interested in joining or re-joining the workforce?	☐ Yes	☐ No
IF YES, DESCRIBE		
Is there any history that would prevent you from a particular job or volunteering?	☐ Yes	☐ No
Would you like to learn a new trade or go back to school?	☐ Yes	☐ No
Would you like to volunteer somewhere?	☐ Yes	☐ No
Would you like to meet with a Benefits Specialist?	☐ Yes	☐ No
Has a referral been made to Missouri Division of Vocational Rehabilitation?	☐ Yes	☐ No
Would you like to contact Missouri Division of Vocational Rehabilitation?	☐ Yes	☐ No

GENERAL NEEDS PLAN ACKNOWLEDGEMENT

I hereby affirm I have completed the General Needs Transition Plan with my Transition Coordinator on the following date:	
Participant Signature	Transition Coordinator Signature

BUDGETING AND FINANCE

Review the following questions with the participant and document their response as well as any concerns or other items on otherwise listed.		
INCOME TYPE(S) – BANK ACCOUNTS, ASSETS, SS/SSI/SSDI, FAMILY MEMBERS, PENSIONS, AND EMPLOYMENT		
Are there benefits you need assistance applying for?	☐ Yes	☐ No
IF YES, DESCRIBE		
Who currently manages your finances? ☐ Self ☐ Guardian ☐ Power of Attorney ☐ Payee ☐ Conservator ☐ Durable Power of Attorney		
If you manage your own finances, do you use a budget?	☐ Yes	☐ No
Does the nursing home receive your income checks and give you an allowance?	☐ Yes	☐ No
Do you receive your check and pay the nursing home yourself?	☐ Yes	☐ No

FUNDING RESOURCES

Due date for Medicaid Review			
Person who assists you with Medicaid Reviews			
Is your Medicaid transferable to another Medicaid program?		☐ Yes	☐ No
Have you requested a transfer to another Medicaid program?		☐ Yes	☐ No
IF YES, LIST THE NAME AND PHONE NUMBER OF THE PERSON ASSISTING WITH THE TRANSFER			
Did you have a Spenddown prior to entering the nursing home?		☐ Yes	☐ No
IF YES, AMOUNT	If yes, are you able to meet your spenddown once you move out?	☐ Yes	☐ No
Was spenddown discussed with you during your options counseling session?		☐ Yes	☐ No
Do you need assistance with spenddown paperwork?		☐ Yes	☐ No
Were you or your spouse a Veteran in the United States Armed Forces?		☐ Yes	☐ No
Have you started transferring your SSI/SSDI from the nursing home to the community?		☐ Yes	☐ No
IF YES, WHEN WAS THE PROCESS STARTED:			

INCOME WORKSHEET

INCOME SOURCE	MONTHLY AMOUNT	COMMENT
SSI	$	
SSDI	$	
SSA	$	
Railroad Retirement	$	
Pension	$	
Employment	$	
Other	$	
Other	$	
TOTAL MONTHLY INCOME	$ 0.00	

EXPENSE WORKSHEET

INCOME SOURCE	MONTHLY AMOUNT	COMMENT
Rent/Mortgage	$	
Homeowner/Renter Insurance	$	
Property Taxes	$	
Home Repairs/Maintenance/Dues	$	
Home Improvements	$	
Electric	$	
Water/Sewer	$	
Natural Gas	$	
Propane	$	
Telephone – Landline	$	
Telephone – Cell Phone	$	
Groceries	$	
Restaurant Meals	$	
Cleaning Supplies	$	
Laundry Supplies	$	
Personal Care Supplies	$	
Clothing	$	
Child Care	$	
Alimony	$	
Child Support	$	
Medical Insurance/Spenddown	$	
Medical Co-Pays	$	
Medical Supplies	$	
Fitness	$	
Car Payment	$	
Auto Insurance	$	
Auto Fuel	$	
Auto Repairs/Maintenance/Fees	$	
Personal Property Taxes	$	
Taxis and Other Transportation	$	
Credit Cards	$	
Student Loans	$	
Other Loans	$	
Cable/Satellite TV	$	
Internet	$	
Hobbies	$	
Subscriptions/Dues	$	
Vacations	$	
Pet Food/Grooming/Vet Care	$	
Other	$	
Other	$	
TOTAL MONTHLY EXPENSES	$ 0.00	
TOTAL MONTHLY INCOME LESS TOTAL MONTHLY EXPENSES		$0
COMMENT REGARDING NET INCOME		

FINANCE AND BUDGET PLAN ACKNOWLEDGEMENT

I hereby affirm I have completed the Finance and Budget Transition Plan with my Transition Coordinator on the following date:	
Participant Signature	Transition Coordinator Signature

HOUSING

Review the following questions with the participant and document their response as well as any concerns or other items on otherwise listed.

WHERE ARE YOU PLANNING TO LIVE/MOVE?

Have you obtained a housing life from the Transition staff?	☐ Yes	☐ No
What is the realistic TARGET move date? (at least 3 months is recommended)		
What city would you like to live in?		
If housing is unavailable, are you interested in living in another city?	☐ Yes	☐ No

IF YES, WHERE?

Are you receiving any help with paying for your housing?	☐ Yes	☐ No

Review housing options with the participant. Please indicate their first and second choices.

FIRST CHOICE		SECOND CHOICE	
Home/Apartment		Home/Apartment	
Address		Address	
Contact		Contact	
Housing Phone		Housing Phone	
Rent	$	Rent	$
Avg. Utilities	$	Avg. Utilities	$
Deposit Amount	$	Deposit Amount	$
Is it Accessible	☐ Yes ☐ No	Is it Accessible	☐ Yes ☐ No
Pet Allowed	☐ Yes ☐ No ☐ N/A	Pet Allowed	☐ Yes ☐ No ☐ N/A
Pet Cost	$ ☐ N/A	Pet Cost	$ ☐ N/A
Waiting List	☐ Yes ☐ No	Waiting List	☐ Yes ☐ No
Length of Wait		Length of Wait	
Are you on Waitlist	☐ Yes ☐ No	Are you on Waitlist	☐ Yes ☐ No

LIVING ARRANGEMENTS

☐ Alone ☐ With Family ☐ With Friends ☐ With Roommates ☐ Other

IF ALONE, WHO WOULD YOU CALL IF YOU NEEDED ASSISTANCE?

Name: Phone: Relationship:

Do you have any type of criminal history which could prohibit you from living in some housing complexes?	☐ Yes	☐ No

IF YES, EXPLAIN

Do you have past evictions, unpaid rent or poor credit history which might impact you living in subsidized housing?	☐ Yes	☐ No

IF YES, EXPLAIN

Do you want internet? If yes, pricing: $	☐ Yes	☐ No

OTHER CONCERNS/ITEMS OF INTEREST

HOUSING INSPECTION

Upon inspection of the property(s), please indicate any issues or concerns that must be addressed prior to transitioning the participant into this housing.
EXPLAIN

Property Address	

HOUSING INSPECTION

Date of Lease		Participant Reviewed Lease?	☐ Yes	☐ No
Date Housing Secured		Date to Receive Keys		
Date Rent/Deposit Paid		Scheduled Move Date		
Utilities Hook-Up		Telephone Hook-Up		
Cable/Satellite Hook-Up		Duplicate Keys Made	☐ Yes	☐ No
Internet Hook-Up		Duplicate Keys Given To		

UTILITIES

Have you scheduled an appointment for telephone service to be installed?			☐ Yes	☐ No
If yes, date service will be turned on				
Have you scheduled an appointment for electricity to be turned on?			☐ Yes	☐ No
If yes, date service will be turned on		Do you owe back payments?	☐ Yes	☐ No
Have you scheduled an appointment for gas to be turned on? ☐ N/A			☐ Yes	☐ No
If yes, date service will be turned on		Do you owe back payments?	☐ Yes	☐ No
Have you requested the Post Office change your address?			☐ Yes	☐ No

HOUSING PLAN ACKNOWLEDGEMENT

I hereby affirm I have completed the Housing Transition Plan with my Transition Coordinator on the following date:	
Participant Signature	Transition Coordinator Signature

24- HOUR EMERGENCY BACKUP PLAN ACKNOWLEDGEMENT

I hereby affirm I have completed the 24-Hour Emergency Backup Plan with my Transition Coordinator on the following date: . A copy of the plan has been provided to me.	
Participant Signature	Transition Coordinator Signature

NURSING HOME CONTACT DATES/DISCHARGE NOTES

Document any communication/information regarding the assistance in this transition:

24-HOUR EMERGENCY BACKUP

This plan is for the safety and well-being of the participant. It identifies how to respond to and address any lapse in essential services and other circumstances that could have a negative effect on participant health, safety, or welfare. In case of an emergency intervention, the contractor has permission to contact local authorities.

PARTICIPANT NAME

Do you have a Lifeline?	☐ Yes	☐ No	NOTE
Do you have an Emergency Dialer?	☐ Yes	☐ No	NOTE
Do you have support from a provider?	☐ Yes	☐ No	PROVIDER NAME

IF THERE ARE OTHER AGREED UPON RESOURCES INCLUDING FORMAL & INFORMAL SUPPORTS, PLEASE DESCRIBE

PRIMARY 24-HOUR CONTACT		OTHER EMERGENCY CONTACT	
Contact Name		Contact Name	
Address		Address	
Phone		Phone	

OTHER EMERGENCY CONTACT		OTHER EMERGENCY CONTACT	
Contact Name		Contact Name	
Address		Address	
Phone		Phone	

Do you use any adaptive equipment?	☐ Yes	☐ No	IF YES, DESCRIBE
Do you use oxygen?	☐ Yes	☐ No	
Do you use a wheelchair?	☐ Yes	☐ No	IF YES ☐ Manual ☐ Electric EXTRA BATTERIES? ☐ Yes ☐ No
Is home owned or rented?			☐ Owned ☐ Rented

LANDLORD NAME	LANDLORD PHONE

Home has smoke detectors?	☐ Yes	☐ No	LOCATION
Home has fire extinguisher?	☐ Yes	☐ No	LOCATION
Flashlights?	☐ Yes	☐ No	LOCATION
Travel/Emergency Radio	☐ Yes	☐ No	LOCATION
Emergency Supplies?	☐ Yes	☐ No	LOCATION

Community's Warning Signal	☐ Siren	☐ Whistle	☐ Flashing Device	☐ Unknown
How do you heat your home?	☐ Electric	☐ Gas	☐ Other:	
How do you heat your water?	☐ Electric	☐ Gas	☐ Other:	
What type of stove do you have?	☐ Electric	☐ Gas	☐ Other:	
Microwave?	☐ Yes	☐ No		
Pets? ☐ N/A	☐ Dog	☐ Cat	☐ Bird	☐ Other:
Prescribed Medications & Frequency	ATTACH LIST FROM PHARMACY			
Treatments	☐ Yes	☐ No	TYPE	
If yes, describe location and frequency				
What is your likelihood of receiving transportation in case of an emergency?	☐ Very Good	☐ Good	☐ Maybe	☐ Unlikely
Have you received Ready-in-3 Emergency Info?	☐ Yes	☐ No		