ATTACHMENT F Revised 2016

Money Follows the Person Transition Plan

PARTICIPANT INFORMATION

Last Name, First Name:		Date of Birth:
Phone: ( ) - -		Email:
Medicaid Number:	MFP Approval Date:	Date Transition Plan Started:
Additional comments regarding the individual that may be pertinent:		

MFP CONTRACTOR INFORMATION

MFP Contractor Name:	Transition Coordinator Name:
Transition Coordinator Phone: ( ) - -	Transition Coordinator Email:
MFP Regional Coordinator:	Region:
Additional comments regarding MFP contractor:	

SKILLED NURSING FACILITY INFORMATION

Facility Name:	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.		
Property Address:	County:	Phone: ( ) - -

PERMISSION STATEMENT

I affirm that I have met with the Transition Specialist, listed below and I give my permission to my Transition Specialist 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 Specialist 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 Specialist 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, and DSDS MFP 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

Healthcare Provider:

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 to the community, do you have an appointment scheduled within two weeks of transition? ☐ Yes ☐ No

Will your doctor prescribe a 30-day supply of medication? ☐ Yes ☐ Yes ☐ NA (no medications)

Doctor's Name:

Doctor's Address:

Doctor's Phone: ( ) - -

Pharmacy Information:

Have you selected a pharmacy? ☐ Yes ☐ Yes ☐ NA (take no medications)

If "yes":

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone: ( ) - -

Does the pharmacy deliver? ☐ Yes ☐ No ☐ NA (take no medications)

Other:

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

If you answered "yes" please explain in detail:

MENTAL HEALTH NEEDS

Check all that apply:

Have you received mental health services of 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 ☐ NA (take no medications)

Do you have a preference for a mental health provider? ☐ Yes ☐ No ☐ NA

If "yes":

Mental Health Provider Name:

Mental Health Provider Address:

MENTAL HEALTH NEEDS

Mental Health Provider Phone: ( ) - -

Describe the Mental Health Plan including eligible programs, resources and supervision physician:

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

If you answered "yes" to a history of alcoholism or drug use, explain circumstances:

If you answered "yes" to a history of alcoholism or drug use, explain the substance abuse program including counseling / treatment dates and times:

PERSONAL HEALTH NEEDS

(Please attach Plan of Care)

Do you have your physician's approval for nursing home transition? ☐ Yes ☐ No

Doctor's Name:

Doctor's Address:

Doctor's Phone: ( ) - -

Do you need assistance with bathing? ☐ Yes ☐ No

Check all that apply:
☐ Bathing in tub ☐ Bathing in bed ☐ Sponge bath

Do you need assistance with dressing? ☐ Yes ☐ No

Check all that apply:
☐ Lower extremities ☐ Upper extremities ☐ No assistance needed

Do you need assistance with toileting? ☐ Yes ☐ No

Check all that apply:
☐ With pads ☐ Getting on and off the commode ☐ No assistance needed

Do you need assistance with bladder care? ☐ Yes ☐ No

Check all that apply:
☐ Catheter ☐ Urinal ☐ Other ☐ No assistance needed

Do you need assistance with bowel care? ☐ Yes ☐ No

Check all that apply:
☐ Suppositories ☐ Laxatives ☐ Other ☐ No assistance needed

Do you need assistance eating? ☐ Yes ☐ No

Check all that apply:
☐ Feeding ☐ Set up ☐ Cutting Food ☐ Clean up ☐ Meal preparation

Do you need assistance with housekeeping? ☐ Yes ☐ No

Check all that apply:
☐ Dusting ☐ Mopping ☐ Vacuuming ☐ General cleaning ☐ Other ☐ No assistance needed

PERSONAL HEALTH NEEDS

(Please attach Plan of Care)

Do you need assistance transferring from one place to another? ☐ Yes ☐ No

Check all that apply:
☐ Hoyer lift ☐ Pivot lift ☐ Staff to assist with equipment ☐ Other ☐ No assistance needed

Provide names and phone numbers of *three* supportive family members, friends or community advocates:

Name:	Phone:	Relationship:
	( ) - -	
Name:	Phone:	Relationship:
	( ) - -	
Name:	Phone:	Relationship:
	( ) - -	

ASSISTIVE TECHNOLOGY / DEVICES SERVICES

Do you currently use any assistive technology devices (include DME)? ☐ Yes ☐ No

If yes, describe equipment:

Do you need adaptive equipment to assist you with your independent living needs? ☐ Yes ☐ No

If yes, describe equipment:

Do you think you need an assessment to find out what kind of assistive technology would work best for you? ☐ Yes ☐ No

If assistive technology is required, have you ordered the equipment? ☐ Yes ☐ No ☐ NA

If you require assistive technology, have you worked out a plan for payment for this equipment?
☐ Yes ☐ No ☐ NA

If assistive technology is needed, do you need funding assistance to purchase this equipment?
☐ Yes ☐ No ☐ NA

Have you worked out a delivery plan for the equipment? ☐ Yes ☐ No ☐ NA

Do you need assistance in learning how to use the technology/devices or equipment?
☐ Yes ☐ No ☐ NA

*** For additional assistance on assistive technology, call MO A/T (800) 647-8557. ***

FURNISHING YOUR HOME

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 SERVICES

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 SERVICES

Do you need independent living skills training in this area? ☐ Yes ☐ No
Have you coordinated a plan so that you can purchase, cook and eat meals? ☐ Yes ☐ No
Who will do the initial shopping for groceries and supplies?

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 independent living 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 / VOLUNTEER

Are you interested in joining or re-joining the workforce? ☐ Yes ☐ No
If interested in joining or re-joining the workforces, what are you interested in doing?
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? ☐ Yes ☐ No
Would you like to meet with a benefit specialist? ☐ Yes ☐
Has a referral been made to Vocational Rehabilitation? ☐ Yes ☐ No
Would you like to contact Vocational Rehabilitation? ☐ Yes ☐ No

GENERAL NEEDS TRANSITION PLAN ACKNOWLEDGEMENT

I hereby affirm that I completed the General Needs Transition Plan with my Transition Coordinator on the following date:	
Participant or Legal Representative Signature (Optional) Date	Transition Coordinator Signature Date

BUDGETING AND FINANCE MANAGEMENT

Review the following questions with the participant and document their response and any concerns or other items not otherwise listed.
Type of Income, not limited to bank accounts, assets, SS/SSI/SSDI, family members, pensions, and employment:
Are there benefits you need assistance applying for?
Who currently manages your finances? ☐ Self ☐ Payee ☐ Power of Attorney ☐ Durable Power of Attorney ☐ Conservator ☐ Guardian
If you manage your own finances, do you use a budget? ☐ Yes ☐ No (If yes, provide copy)
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

BUDGETING AND FINANCE MANAGEMENT

For transitioning purposes and to ensure your success in the community, a budget will be created. You will need to gather all information regarding payments you currently have, other outstanding debts, income statements, etc. Developing a budget will ensure that you can afford the housing and accommodations in which you have indicated an interest.

GENERAL NEEDS TRANSITION PLAN ACKNOWLEDGEMENT

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

______________________________ Participant or Legal Representative Signature Date (Optional)	______________________________ Transition Coordinator Signature Date

FUNDING RESOURCES

Due date for Medicaid reinvestigations:

Who assists you with Medicaid updates?

Is your Medicaid transferable to another Medicaid program? ☐ Yes ☐ No

Have you requested a transfer? ☐ Yes ☐ No

What is the name and phone number of the person assisting you with this transfer?
Name: Phone: ( ) - -

Are you able to meet your spenddown once you move out? ☐ Yes ☐ No

Was this discussed with you in your option counseling session? ☐ Yes ☐ No

Do you need assistance with spenddown paperwork? ☐ Yes ☐ No

Will you be eligible for Veteran's Services? ☐ Yes ☐ No

Have you started transferring your SSI/SSDI from the nursing home to the community?

☐ Yes ☐ No

If so, when was the process started?

INCOME AND EXPENSE WORKSHEET

Income Source	**Monthly Amount**	**Comment**
Supplemental Security Income (SSI)	$	
Social Security Disability Income (SSDI)	$	
Social Security Retirement Income (SSA)	$	
Railroad Retirement	$	
Pension	$	
Employment	$	
Other	$	
Other	$	
Total Monthly Income	**$**	

Expense Type	**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	$	
Groceries	$	
Restaurant Meals	$	
Cleaning Supplies	$	
Laundry and 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 Tax	$	
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	**$**	

TOTAL MONTHLY INCOME LESS TOTAL EXPENSES =	**$**
Comment Regarding Net Income:	

HOUSING IDENTIFICATION

Review these questions with the participant and document their response and any concerns or other items not

HOUSING IDENTIFICATION

otherwise listed.

Where are you planning to live / move?

Have you obtained a housing list from the Transition staff? ☐ Yes ☐ No

What is the realistic TARGET move date? (at least three 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 option with the Participant. Below, please indicate their first and second choices.

First Choice	Second Choice
Home/Apt: Address: Contact: What is their phone number: ( ) - -	Home/Apt: Address: Contact: What is their phone number: ( ) - -
What is the rent? $ Average utility cost? $ Amount of deposit? $	What is the rent? $ Average utility cost? $ Amount of deposit? $
Is it accessible for your needs? ☐ Yes ☐ No	Is it accessible for your needs? ☐ Yes ☐ No
If you want pets, are they allowed? ☐ Yes ☐ No NA ☐ If pets are allowed, what is the additional cost? $	If you want pets, are they allowed? ☐ Yes ☐ No NA ☐ If pets are allowed, what is the additional cost? $
Is there a waiting list? ☐ Yes ☐ No If yes, how long? Are you on the waiting list? ☐ Yes ☐ No	Is there a waiting list? ☐ Yes ☐ No If yes, how long? Are you on the waiting list? ☐ Yes ☐ No

What will your living arrangements be? (i.e. living along, with roommates, with family, etc.)

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

If you will be living 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 residing in some housing complexes? ☐ Yes ☐ No

If "yes" please explain:

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

If "yes" please explain:

Do you want internet? ☐ Yes ☐ No

If "yes" have you check pricing? ☐ Yes ☐ No

Other concerns or 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.
What is the address of the property?

HOUSING APPROVAL

Date of lease:	Has participant reviewed lease? ☐ Yes ☐ No
Date housing secured:	Date to receive keys:
Date deposit & rent paid:	Scheduled move date:
Utilities hook up:	Telephone hook-up:
Cable/satellite hook-up:	Duplicate keys made? ☐ Yes ☐ No
Internet hookup:	Duplicate keys given to:

HOUSING PLAN ACKNOWLEDGEMENT

I hereby affirm that I completed the Housing Transition Plan with my Transition Coordinator on the following date:

Participant or Legal Representative Signature Date (Optional)	Transition Coordinator Signature Date

UTILITY SERVICES

Have you scheduled an appointment for telephone service to be installed? ☐ Yes ☐ No Date service will be turned on:
Do you currently have a mobile/cell phone? ☐ Yes ☐ No
Have you scheduled an appointment for electricity to be turned on? ☐ Yes ☐ No Date service will be turned on: Do you owe any back payments? ☐ Yes ☐ No
Have you scheduled an appointment for gas to be turned on? ☐ Yes ☐ No Date service will be turned on: Do you owe any back payments? ☐ Yes ☐ No
If you want cable television, have you made an appointment for installation? ☐ Yes ☐ No
Have you requested the Post Office to change your address? ☐ Yes ☐ No

24-HOUR EMERGENCY BACKUP STRATEGY

This plan is for the safety and well-being of the individual listed below. 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 or welfare. In case of emergency intervention, the contractor has permission to contact local authorities.

Participant's Name:

24-HOUR EMERGENCY BACKUP STRATEGY

The backup plan may include the following:

Do you have a Lifeline? ☐ Yes ☐ No

Do you have an Emergency Dialer? ☐ Yes ☐ No

Support from a provider? ☐ Yes ☐ No

Other agreed upon resources? ☐ Yes ☐ No

If "yes" please describe:

Primary contact for 24-hour telephone access.

Primary Contact:

Primary Contact Phone: ( ) - -

Primary Contact Address:

Informal supports? ☐ Yes ☐ No

If "yes" please describe:

Any additional emergency contacts? ☐ Yes ☐ No

If "yes", please complete the necessary contact information below:

Emergency Contact:

Phone: ( ) - -

Address:

Emergency Contact:

Phone: ( ) - -

Address:

Emergency Contact:

Phone: ( ) - -

Address:

Do you use any adaptive equipment? ☐ Yes ☐ No

Do you use oxygen? ☐ Yes ☐ No ***(Do not use oxygen in case of a fire!)***

Do you use a wheelchair? ☐ Yes ☐ No

If "yes", what type? ☐ Manual ☐ Electric

If an electric wheelchair, do you have extra batteries? ☐ Yes ☐ No

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Home is: ☐ Owned ☐ Rented

If home is rented:

Landlord Name:

Landlord Phone: ( ) - -

24-HOUR EMERGENCY BACKUP STRATEGY

Home has smoke detectors? ☐ Yes ☐ No
If "yes", describe location:

Home has fire extinguisher? ☐ Yes ☐ No
If "yes", describe location:

Flashlight? ☐ Yes ☐ No
If "yes", describe location:

Travel/Emergency radio? ☐ Yes ☐ No
If "yes", describe location:

The community's warning signal is: ☐ Siren ☐ Whistle ☐ Flashing device ☐ Unknown

Emergency Supplies? ☐ Yes ☐ No
If "yes", describe location:

How do you heat your home? ☐ Electric ☐ Gas ☐ Other (specify)

What heats your water? ☐ Electric ☐ Gas ☐ Other (specify)

What type of stove do you have? ☐ Electric ☐ Gas ☐ Other (specify)

Microwave? ☐ Yes ☐ No

Do you have pets? ☐ Yes ☐ No

If "yes" what kind? ☐ Dog ☐ Cat ☐ Bird ☐ Other (specify)

Prescribed Medications & Frequency: (Attach list from pharmacy)

Treatments? ☐ Yes ☐ No Type:

Describe location and frequency:

What is your likelihood of receiving transportation in case of an emergency?
☐ Very Good ☐ Good ☐ Maybe ☐ Unlikely

Have you received the Ready in 3 Emergency Information? ☐ Yes ☐ No

24-HOUR EMERGENCY BACKUP STRATEGY ACKNOWLEDGEMENT

I certify the above 24-hour Emergency Backup Strategy was developed in cooperation with the individual and a copy of the Plan has been provided to the participant.

Participant or Legal Representative Signature Date (Optional)	Transition Coordinator Signature Date

NURSING HOME CONTACT DATES / DISCHARGE NOTES

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