*Referral made by: Date/Time of Referral:*

*Contact information for referral source:*

Transition Navigator:

***Section 1: Participant Information and Pre-Meeting Contact***

**Participant Information:**

Name: Date of Birth: Gender:

How do you prefer to be addressed?

SS#: Can we contact the NF? ⧠ Yes ⧠ No

Marital Status: ⧠ Married ⧠ Divorced ⧠ Single/Never Married ⧠ Separated ⧠ Widowed

Nursing Facility Contact Information:

How would you like to be contacted?

Informal Support Person and Contact Info:

Legal Support Person Contact Info

Communication Support Needs:

**In-Person Appointment:** *(Have a conversation with the individual to determine the best time for you to meet with them in person)*

Scheduled Appointment Date and Time:

Is there anyone else you would like at the appointment? ⧠ Yes ⧠ No

If yes, person/contact info if different from above:

Would you like me to make contact on your behalf? ⧠ Yes ⧠ No

If yes, contact made date and time:

If no, person understands they will need to contact the individual(s): ⧠Yes ⧠ No

What additional information would you like me to know?

**Notes:**

Date of In-Person Meeting:

In-Person Introduction (check off after explaining/doing): *(This serves as a reminder to the transition navigator of topics to cover during the in person meeting. The participant experience map is not yet available.)*

\_\_\_\_\_ Introduce yourself \_\_\_\_\_ Introduce Program

\_\_\_\_\_ Offer Participant Experience Map \_\_\_\_ Sign ROI Form/Agree to participate

***Section 2: Your Move to the Nursing Facility***

What day did you move to this nursing facility (NF)?

Were you in a hospital or rehabilitation facility immediately before coming to the NF? ⧠Yes ⧠ No

Hospital: Admit Date: Discharge Date:

Rehab: Admit Date: Discharge Date:

Comments:

What changes occurred in your life that led you to move to a nursing facility? (Prompts: changes in medical conditions, physical capacity, or family supports):

Who made the decision for you to move into the NF?

⧠ You ⧠ Doctor: ⧠ Family: ⧠ Other:

Comments:

Medical Conditions/Diagnosis:

Transition Navigator Observations:

Review information with nursing facility staff and note any differences:

Where were you living before moving to the NF?

Address (if known):

Did you live alone or with others? ⧠ Alone ⧠ W/Others

If others, whom?

Are you able to return to your previous residence? ⧠Yes ⧠ No

If no, please explain:

Why do you want to leave the nursing facility?

**Notes:**

***Section 3: Support System:***

**DPOA, Guardian, Paid Advocate, Conservator:**

Do you have any of the following decision makers in place?

Conservator ⧠ Yes ⧠ No Paid Advocate ⧠ Yes ⧠ No

DPOA ⧠ Yes ⧠ No Guardian ⧠ Yes ⧠No

Representative Payee ⧠ Yes ⧠ No Patient Advocate ⧠ Yes ⧠ No

If yes to any of the above, is it activated? ⧠ Yes ⧠ No

Are copies of the legal papers available? ⧠ Yes ⧠ No

If yes, does the transition navigator have the documents on file? ⧠ Yes ⧠ No

If no, what is the plan for obtaining copies of the legal papers?

Contact information for those marked “yes” above

Name/Role:

Address:

Phone(s): Date appointed:

Name/Role:

Address:

Phone(s): Date appointed:

If any of the above legal decision makers apply, have you spoken with them about your interest to move from the NF? ⧠ Yes ⧠ No

If yes, are they supportive? ⧠ Yes ⧠ No

If not, what are the concerns?

How do you feel about these concerns?

If you have not contacted them, would you like me to make contact on your behalf? ⧠ Yes ⧠ No

(If consumer has a guardian, inform them you will need to contact them to sign paperwork.)

**Informal Supports:**

Do you have family or friends who you want to be involved in your transition plan? ⧠ Yes ⧠ No

If yes, who are they?

Name/Relationship:

Contact Info:

Name/Relationship:

Contact Info:

Name/Relationship:

Contact Info:

Have you spoken to them about your interest in moving? ⧠ Yes ⧠ No

If yes, are they supportive? ⧠ Yes ⧠ No

If not supportive, what are their concerns? How do you feel about these concerns?

How often do you have contact with them?

Do they live near you? ⧠ Yes ⧠ No

Is there anyone you do NOT want involved in the transition planning? ⧠ Yes ⧠ No

If yes, whom?

Is there NF staff that you would like to be involved in your transition? ⧠ Yes ⧠ No

If yes, whom?

**Notes:**

**Previous or Recent Assistance:**

Before going to the nursing home, did you receive assistance in your home? ⧠ Yes ⧠ No

If yes, type of supports and service:

| **Type of Service/Support** | **Name of Agency or Informal Supports** | **Contact Person and Information** | **Supports Received** |
| --- | --- | --- | --- |
| ⧠ Family & Friends |  |  |  |
| ⧠ MI Choice Waiver |  |  |  |
| ⧠ MI Health Link |  |  |  |
| ⧠ Adult Home Help |  |  |  |
| ⧠ CMH |  |  |  |
| ⧠ Home Health/Skilled Care |  |  |  |
| ⧠ Community Services |  |  |  |
| ⧠ Grant Funded Services |  |  |  |
| ⧠ Hospice |  |  |  |
| ⧠ PACE |  |  |  |
| ⧠ Adult Protective Services |  |  |  |
| ⧠ Self- or Private- Pay |  |  |  |
| ⧠ Other |  |  |  |

Do you feel these services were meeting your needs prior to your NF stay? ⧠ Yes ⧠ No

If no, explain:

Has your health changed since before coming to the nursing facility? ⧠ Yes ⧠ No

Do you want to restart those services when you get home? ⧠ Yes ⧠ No

If no, explain:

***Section 4: Functional Abilities & Medical Equipment Needs***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Level of Independence and Capacity to Perform:** | **Does not know** | **Independent** | **Set up or supervision** | **Hands on Assistance** | **Fully Dependent** | **T.Spec. verify/ agree** | **NF Staff verify/agree** |
| **IADLs** |  |  |  |  |  |  |  |
| Shopping |  |  |  |  |  |  |  |
| Meal Prep |  |  |  |  |  |  |  |
| Transportation |  |  |  |  |  |  |  |
| Managing Meds |  |  |  |  |  |  |  |
| Phone use |  |  |  |  |  |  |  |
| Housework |  |  |  |  |  |  |  |
| Managing finances |  |  |  |  |  |  |  |
| Negotiating Stairs |  |  |  |  |  |  |  |
| Laundry |  |  |  |  |  |  |  |
| **ADLs** |  |  |  |  |  |  |  |
| Showering/Bathing |  |  |  |  |  |  |  |
| Dressing self |  |  |  |  |  |  |  |
| Eating |  |  |  |  |  |  |  |
| Toileting |  |  |  |  |  |  |  |
| Personal Hygiene |  |  |  |  |  |  |  |
| Bed Mobility |  |  |  |  |  |  |  |
| Transferring |  |  |  |  |  |  |  |
| Locomotion |  |  |  |  |  |  |  |
| **Other** |  |  |  |  |  |  |  |
| Night Time care |  |  |  |  |  |  |  |
| Incontinence care |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Explain Transition Specialist differences, if any:

Explain NF staff differences, if any:

Current NFLOC Door (from NF Staff):

How long does NF Staff expect individual to meet NFLOC criteria?

**Notes/ADL log review:**

***Section 5: Financial Information:***

**Insurance:**

Do you have Medicaid?

⧠ No Have you applied? ⧠ Yes ⧠ No If yes, when:

Are you interested in applying? ⧠ Yes ⧠ No (If yes, refer to NF SW)

Date and time referral given to NF SW:

⧠ Yes Medicaid ID# Type:

MDHHS Worker Contact Information, if known:

Do you have Medicare? ⧠A ⧠B ⧠C ⧠D Medicare # ⧠ No Medicare

If part B, premium amount: Is this deducted from check? ⧠ Yes ⧠ No

If part D, carrier:

Do you have supplemental insurance? ⧠ Yes ⧠ No Carrier:

If both Medicare and Medicaid, is individual enrolled with MI Health Link? ⧠ Yes ⧠ No

If yes, date and time referral given to MI Health Link:

Do you have Long Term Care Insurance? ⧠ Yes ⧠ No Carrier:

Are you a Veteran? ⧠ Yes ⧠ No Are you the spouse of a Veteran? ⧠ Yes ⧠ No

If yes, branch of service:

If yes, did you serve in active duty (i.e. wartime)? ⧠ Yes ⧠ No

If Veteran or Spouse, have you applied for benefits? ⧠ Yes ⧠ No If so when?

If no, would you like more information? ⧠ Yes ⧠ No

Referral or resources given:

**Income:**

What type and amount of income do you receive on a regular basis?

Type: Amount (monthly): ⧠ Net ⧠ Gross

Type: Amount (monthly): ⧠ Net ⧠ Gross

Type: Amount (monthly): ⧠ Net ⧠ Gross

*If no SS income, ask*: Have you applied for SS benefits?

⧠ Yes Were you denied benefits? ⧠ Yes ⧠ No Date Applied: Have you appealed? ⧠ Yes ⧠ No Date Appealed:

⧠ No Do you need assistance applying for SS benefits? ⧠ Yes ⧠ No

Referral given to:

Do you have proof of your income? ⧠ Yes ⧠ No

**Notes on Insurance and Income:**

**Assets:**

Do you have a:

Checking account: ⧠ Yes ⧠ No Balance:

Savings account: ⧠ Yes ⧠ No Balance:

Direct Express card: ⧠ Yes ⧠ No Balance:

Other financial resources (CD’s, Stocks, Bonds, IRA, Life insurance, etc.): ⧠ Yes ⧠ No

Type: Amount/Value:

Type: Amount/Value:

Type: Amount/Value:

Type: Amount/Value:

If no bank accounts, do you want to open one? ⧠ Yes ⧠ No

If yes, what financial institution?

What is your plan for opening an account?

If assets exceed $2,000 asset limit for Medicaid, what is your plan for addressing excess assets?

**Outstanding Debts:**

Do you have outstanding debts? ⧠ Yes ⧠ No

Type: Amount Owed:

Type: Amount Owed:

Type: Amount Owed:

Type: Amount Owed:

Do you have a plan to address your outstanding debts? ⧠ Yes ⧠ No

If yes, what is your plan?

If no, is anyone helping you address these issues? ⧠ Yes ⧠ No

If yes, whom:

If no, would you like to speak to someone to address these issues? ⧠ Yes ⧠ No

If yes, referral made to, date, and time:

**Notes on Financial Information:**

***Section 6: Barriers to NF Discharge and Community Living:***

What, if any, fears or concerns do you have about moving back to the community?

**Transition Opposition:**

Is anyone opposed to you moving out of the nursing facility? ⧠ Yes ⧠ No

If yes, who?

Why are they opposed?

If yes, what is your plan?

**Identification:**

Do you have identification (check if they have the I.D.)?

⧠ Picture ID ⧠ Driver’s License ⧠ SS Card ⧠ Birth Certificate

⧠ Veteran DD214 ⧠ Medicare Card ⧠ Medicaid Card ⧠ Other Insurance card

Where is your identification?

If no identification or missing identification, do you need assistance obtaining it? ⧠ Yes ⧠ No

If yes, what is your plan?

Referral/Resources given to: Date/Time given:

**Harmful Behaviors or Actions:**

Do you or have others told you that you resist care? ⧠ Yes ⧠ No

If yes, please explain:

Do you curse or threaten others? ⧠ Yes ⧠ No

If yes, please explain:

Do you have hallucinations or delusions? ⧠ Yes ⧠ No

If yes, please explain:

Are you currently any receiving counseling or therapy? ⧠ Yes ⧠ No

If yes, please explain:

Do you have concerns with harmful behaviors or actions toward yourself or others? ⧠ Yes ⧠ No

If yes, what are your concerns about these behaviors or actions?

Transition Specialist Observations:

Review information with nursing facility staff and note any differences:

If harmful behaviors or actions are present, what is your plan?

If no plan, would you like assistance with developing a plan? ⧠ Yes ⧠ No

If yes, referral given to: Date/Time given:

Are you interested in obtaining mental health services? ⧠ Yes ⧠ No

If yes, referral given to: Date/Time given:

**Housing:**

⧠ Yes, I have a home to return to (check box if true, skip to next question if false)

Do you rent or own your home? ⧠ Rent ⧠ Own

Are you current with your rent, mortgage, and taxes? ⧠ Yes ⧠ No

If no, what is your plan to address this?

Does your home need any of the following services before you can return (check if yes and explain in space provided)?

⧠ Home modification?

⧠ Repairs?

⧠ Deep Cleaning?

⧠ Pest eradication?

⧠ Utilities?

⧠ Hoarding abatement?

⧠ Other:

⧠ No, I do not have a home to return to.

Do you need assistance finding housing? ⧠ Yes ⧠ No

If yes, date and time referral made to housing specialist:

If no, what are your housing preferences?

What is your plan to secure housing?

**Housing Barriers:**

Do you have funds for a security deposit? ⧠ Yes ⧠ No

If no, what is your plan?

Do you have funds for the first month’s rent? ⧠ Yes ⧠ No

If no, what is your plan?

Do you have furniture? ⧠ Yes ⧠ No

If no, what is your plan?

Do you have household items? ⧠ Yes ⧠ No

If no, what is your plan?

How do you plan to move your belongings from the nursing home back to your residence?

Do you need assistance setting up utility accounts: ⧠ Yes ⧠ No

If yes, check all that apply:

⧠ Electric ⧠ Heat ⧠ Water ⧠ Sewer ⧠ Telephone ⧠ Cable/Satellite

If yes, what is your plan?

**Home Evaluation(s):**

Has the nursing facility staff (OT, PT, SW, Discharge planner) or other professional completed Home Functionality Evaluation? ⧠ Yes ⧠ No

If yes, may I have a copy of the evaluation and recommendations? ⧠ Yes ⧠ No

If yes, copy of evaluation obtained and in chart on: Date/Time:

If no Home Functional Evaluation performed, is one needed? ⧠ Yes ⧠ No

If yes, referral given to: Date/Time given:

Would you like a Home Safety Evaluation?

*Home Safety Evaluation Results:*

Date & time performed with individual present:

Observations:

**Nutritional Barriers:**

Do you consume your meals by mouth? ⧠ Yes ⧠ No

If no, how do you consume your meals?

If you require tube feeding, do you need assistance with this? ⧠ Yes ⧠ No

If yes, what is your plan?

What type of formula do you use?

How is it given? ⧠ Bolus ⧠ Pump ⧠ Other:

Do you have supplies for your nutrition? ⧠ Yes ⧠ No

If no, what is your plan?

Has your doctor prescribed a special diet for you? ⧠ Yes ⧠ No

If yes, what type (check all that apply)? ⧠ Diabetic ⧠ Low Sodium ⧠ Renal

⧠ Calorie Restricted ⧠ High Calorie ⧠ Other (describe):

What texture is your diet? ⧠ Regular ⧠ Pureed ⧠ Mechanical Soft ⧠ Ground Meat

⧠ Other:

Do you use any nutritional supplements between meals or to replace meals? ⧠ Yes ⧠ No

If yes, please describe (example – Ensure/1 can/After every meal):

Type or Brand:

Quantity:

Frequency:

Do you have any problems drinking liquids or require your liquids to be thickened? ⧠ Yes ⧠ No

If yes, describe:

If you require thickened liquids, how thick should they be? ⧠ Honey ⧠ Nectar

Has your doctor told you to limit your fluids? ⧠ Yes ⧠ No

If yes, what is the limit per day?

Transition Specialist Observations:

**Skin Integrity Barriers:**

Do you have any major skin problems? ⧠ Yes ⧠ No

If yes, please describe: ⧠ Lesions ⧠ 2nd or 3rd Degree Burns ⧠ Surgical Wound

⧠ Stage 3/4 Pressure Sore ⧠ Venous Ulceration ⧠ Diabetic Ulceration

⧠ Other:

If yes, what is your treatment plan?

If yes, is your plan for treating it in the community?

Transition Specialist Observations:

**Breathing and Respiration Barriers:**

Do you have shortness of breath? ⧠ Yes ⧠ No

If yes, what activities cause shortness of breath (check all that apply)?

⧠ Dressing ⧠ Walking ⧠ Talking ⧠ Housework ⧠ Bathing

⧠ Shopping ⧠ Climbing stairs ⧠ Meal Prep ⧠ Transferring

⧠ Other:

How do you treat you shortness of breath?

Do you use Oxygen? ⧠ Yes ⧠ No

If yes, what is the rate of flow for your oxygen?

How often (in hours) do you use oxygen in a day?

Can you manage the oxygen without any assistance, including turning it on, setting the rate, putting the cannula on, and switching to a backup tank? ⧠ Yes ⧠ No

If no, what is your plan for managing in the community?

What is your plan for obtaining oxygen in the community?

Do you use a C-pap or Bi-pap machine? ⧠ Yes ⧠ No

If yes, can you manage the C-pap or Bi-pap without any assistance, including setting up the machine, setting the rate, and putting on the mask? ⧠ Yes ⧠ No

If no, what is your plan for managing in the community?

What is your plan for obtaining a C-pap or Bi-pap machine in the community?

Do you use a ventilator? ⧠ Yes ⧠ No

If yes, how often (in hours) do you use the ventilator in a day?

Can you manage the ventilator without any assistance? ⧠ Yes ⧠ No

If no, what is your plan for managing in the community?

What is your plan for obtaining a ventilator in the community?

Transition Specialist Observations:

**Dialysis Barriers:**

Do you receive dialysis? ⧠ Yes ⧠ No

If yes, do you go to a Dialysis Center? ⧠ Yes ⧠ No

If yes, what days of the week do you go to the center (check all that apply):

⧠ Mon ⧠ Tues ⧠ Wed ⧠ Thurs ⧠ Fri ⧠ Sat ⧠ Sun

What dialysis center to you go to?

Contact info (person & number):

How do you get to the dialysis center?

Do you want to continue this arrangement after transition? ⧠ Yes ⧠ No

If yes, do you receive peritoneal dialysis through your abdomen? ⧠ Yes ⧠ No

If yes, what is your plan for managing this at home?

Transition Specialist Observations:

**Medication Barriers:**

Do you take medications? ⧠ Yes ⧠ No

If yes, how do you take your medications?

Do you use any injectable medications (insulin, heparin)? ⧠ Yes ⧠ No

If yes, are you able to inject medications on your own? ⧠ Yes ⧠ No

If you are on a sliding scale for insulin, can you manage this yourself? ⧠ Yes ⧠ No

If no, has the staff at the nursing facility attempted to train you to? ⧠ Yes ⧠ No

What is your plan for receiving the injections at home?

Do you have a need to check your blood sugar? ⧠ Yes ⧠ No

If yes, can you do this yourself? ⧠ Yes ⧠ No

If no, what is your plan?

Transition Specialist Observations:

**Memory Barriers:**

Ask short term memory questions (3 word recall, person place time, etc)

Results:

NF Staff Consultation:

Do you require assistance to make routine daily decisions tasks? (what to wear, what to eat, etc.)

⧠ Yes ⧠ No

If yes, who, if anyone, assists you to make your decisions?

Transition Specialist Observations:

**Community Living Skills:**

Do you need assistance with budgeting or bill paying? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you know how to access transportation? ⧠ Yes ⧠ No

If no, what is your plan?

Do you need help managing dietary needs? ⧠ Yes ⧠ No

If no, what is your plan?

Do you need help preparing meals? ⧠ Yes ⧠ No

If no, what is your plan?

Do you need a Personal Emergency Response System (PERS)? ⧠ Yes ⧠ No

If yes, what is your plan?

Transition Specialist Observations:

**Household Maintenance:**

Do you need assistance with cleaning? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you need assistance with doing laundry? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you need assistance with shopping, including groceries? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you need assistance with meal planning? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you need groceries when you return home? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you need assistance with yard work? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you need assistance with home maintenance? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you have a phone and phone service? ⧠ Yes ⧠ No

If no, what is your plan?

Do you need clothing? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you have working smoke detectors? ⧠ Yes ⧠ No

If no, what is your plan?

Do you have working carbon dioxide detectors? ⧠ Yes ⧠ No

If no, what is your plan?

Do you have a functioning fire extinguisher? ⧠ Yes ⧠ No

If no, what is your plan?

Transition Specialist Observations:

**Socialization:**

Are you concerned about feeling isolated at home? ⧠ Yes ⧠ No

If yes, what is your plan?

Are you interested in social activities? ⧠ Yes ⧠ No

If yes, what is your plan?

Are you interested in faith-based services? ⧠ Yes ⧠ No

If yes, what is your plan?

Are you interested in volunteering or employment opportunities? ⧠ Yes ⧠ No

If yes, what are your areas of interest?

If yes, what is your plan?

Transition Specialist Observations:

**Pets or Service Animals:**

Do you have or want a pet or service animal? ⧠ Yes ⧠ No

If yes, what is your plan?

Are you able to care for a pet or service animal adequately? ⧠ Yes ⧠ No

If no, what is your plan?

If yes, what type of pet?

Pet breed: Weight of pet:

When was the last veterinary checkup for your pet?

Is your pet healthy? ⧠ Yes ⧠ No

Do you have records to verify this? ⧠ Yes ⧠ No

Transition Specialist Observations:

**Health Care, DME, and Assistive Technology:**

What type(s) of mobility or assistive devices to you currently use (i.e. wheelchair, walker, cane, hospital bed, lift chair, shower chair, etc.)?

If you have a device to help you get around (w/c, cane, etc.) do you always use it? ⧠ Yes ⧠ No

Do others remind you to use your device? ⧠ Yes ⧠ No

Have you had any falls in the last 3 months? ⧠ Yes ⧠ No

What medical devices will you need when you go home?

PT, OT, SLP follow up or recommendations:

Do you have a primary care physician in the community? ⧠ Yes ⧠ No

If yes, physician and contact information:

If no, what is your plan?

Do you have a need for skilled care? ⧠ Yes ⧠ No

If yes, what is your preferred agency?

Referral made to: Date:

What pharmacy do you prefer?

Do you use incontinence supplies? ⧠ Yes ⧠ No

If yes, physician’s order obtained from: Date:

If yes, referral made to J&B by: Date:

Do you have a need for dental care? ⧠ Yes ⧠ No

If yes, what is your plan?

Do you have a need for vision care? ⧠ Yes ⧠ No

If yes, what is your plan?

Could you benefit from assistive technology devices? ⧠ Yes ⧠ No

If yes, what is your plan?

Transition Specialist Observations:

**Additional Referrals to Address Concerns:**

Referral made to: Date/Time:

Reason:

Referral made to: Date/Time:

Reason:

Referral made to: Date/Time:

Reason:

Referral made to: Date/Time:

Reason:

**Notes:**

***Section 7: Community Living Preferences:***

What do you want your life to be like at home?

Based on the information we have discussed, you may be eligible for the home and community based services checked below (explain all that apply):

⧠ MI Choice Waiver ⧠ MI Health Link ⧠ Adult Home Help

⧠ Home Health/Skilled Care ⧠ Community Services ⧠ Grant Funded Services

⧠ Hospice ⧠ CMH Services ⧠ PACE

⧠ Adult Protective Services ⧠ Self- or Private- Pay ⧠ SameAddress

⧠ CIL/Community Living Services ⧠ AAA Care Management ⧠ Addiction Services

⧠ Other

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Program Referral Log (for services and supports chosen by individual)** | | | | |
| **Program/Agency** | **Contact Person** | **Contact info** | **Date/Time** | **Follow Up** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Notes:**

**Last Steps:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Transition To Do List** | | | | |
| **TASK** | **TASK ASSIGNED TO** | **TASK COMPLETED BY** | **TASK COMPLETED DATE/TIME** | **PARTICIPANT**  **AGREEMENT (initials)** |
| Order Medications |  |  |  |  |
| Order DME |  |  |  |  |
| Dr. Appt. in community |  |  |  |  |
| Transportation Home |  |  |  |  |
| Make referrals as noted |  |  |  |  |
| Change address w/USPS |  |  |  |  |
| Change address w/SSA |  |  |  |  |
| Notify DHHS of discharge |  |  |  |  |
| Assure Skilled Care in place, if needed |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Authorized Community Transition Services:**

| **Service** | **HCPCS Code** | **Date** | **Description** | **Cost** | **Units** | **Completed by (person/date)** | **Participant Agreement** |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**Authorization and Consent:**

By signing this document below, the participant and/or his/her guardian:

* + Acknowledges risk in transition and agrees to assist with developing the transition plan and to follow the transition plan,
  + Agrees to demonstrate a good faith effort in the transition process, AND
  + Agrees to contact the transition coordinator/care manager if a change affects the person‐centered transition plan before the next review date.

The transition coordinator agrees to monitor the person‐centered transition plan and to update it as necessary or preferred by the participant.

**Signatures:**

Participant Date

Guardian/Legally Responsible Decision Maker/Representative Date

Transition Coordinator Date

Service Provider/Informal Support/Witness Date

Service Provider/Informal Support/Witness Date

Service Provider/Informal Support/Witness Date

Cc: Individual Guardian Transition Coordinator Informal Supports Service Providers

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TRANSITION PLAN REVIEW LOG** | | | | |
|  |  | **Initials in the boxes below indicate the individual has reviewed and understands the changes.** | | |
| **Date of Review** | **Change noted** | **Participant/ Guardian** | **Transition Coordinator** | **Others: i.e. Service Provider, Informal Support, Witness** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Cc: Individual Guardian Transition Coordinator Informal Supports Service Providers