Date of Admission:

Date of Discharge:

DOEA NURSING HOME TRANSITION PLAN

Plan Development Date: Anticipated Waiver: ☐ ADA ☐ ALE
Actual Waiver & Enrollment Date:

A. DEMOGRAPHIC

1. Consumer Name:
2. SSN and/or Medicaid Number:
3. Referral Date (NHTR Start):
4. Facility Name/Address:
5. Facility Contact (Name & Phone):
6. Primary Contact: ☐ Client/☐ Representative (Name & Phone):
7. Relationship to Consumer:
8. Planned Dwelling type: ☐ ALF ☐ w/Family ☐ Private Residence
9. Planned Community Address:
10. Financial Eligibility Packet Sent to DCF? ☐ Yes ☐ No Date Sent:
11. Case Management Agency:
12. Transition Case Manager (Name & Phone):

B. TRANSITION PLAN DEVELOPMENT PARTICIPANTS:

1. Name:
Relationship:
Phone: Address:

2. Name:
Relationship:
Phone: Address:

3. Name:
Relationship:
Phone: Address:

4. Name:
Relationship:
Phone: Address:

C. GOALS & POTENTIAL BARRIERS TO TRANSITION

1. Goal:

Barrier:

Support needed to remove barrier:

Who is providing the support:

Estimated timeframe of resolution:

Progress Notes/Updates:

2. Goal:

Barrier:

Support needed to remove barrier:

Who is providing the support:

Estimated timeframe of resolution:

Progress Notes/Updates:

3. Goal:

Barrier:

Support needed to remove barrier:

Who is providing the support:

Estimated timeframe of resolution:

Time Spent Plan Development:

D. TRANSITION ASSISTANCE NEEDED

Transition Plan Services to start on discharge date:

Provider	Service (ND = Non-DOEA Services) (MW = Waiver Services)	Frequency	Cost

Close out notes:

Time Spent Plan Development:

E. CERTIFICATION

TRANSITION PENDING:

☐ I certify that I have decided to relocate to the community and the items and services listed above are necessary for me to establish a residence in the community. I authorize, [*Name of Agency and Name of Transition Case Manager*], to assist me with the coordination of services and purchases necessary for me to transition.

☐ I am also aware that I (or my Representative) will be expected to: assist with transition activities (e.g. housing applications, reinstating utility services, etc.), secure family and community support, provide complete and accurate medical history, (including all treatments, interventions, prescribed and over-the-counter medications), provide accurate information regarding Medicaid, Medicare, VA or other medically-related insurance programs to the case manager, ask questions when I do not understand my services and, report any significant changes in my medical condition, circumstances, informal supports and formal supports to the case manager.

OR TRANSITION DECLINED:

☐ I understand my options for long-term care assistance and have discussed these options with the transition case manager. I am aware that I have the right to choose whether or not to join any Medicaid long-term care program, including the right to choose nursing home care. At this time, I am no longer interested in nursing home transition, and I have chosen to remain in the nursing home.

OR CURRENTLY UNABLE TO TRANSITION:

☐ I certify that I understand and agree with the reasons why I am currently unable to transition to the community.

Reason(s) not able to transition currently (if applicable):

1.

2.

Time Spent Plan Development:

_____ _____

Signature-Consumer/Representative Date

_____ _____

Signature-Transition Case Manager Date

TRANSITION BILLING:

Total Time for Transition: Total Units for Transition: ☐ CIRTS updated

Copies of plan sent to: ☐ Individual Date: ☐ CARES Date:

☐ ARC/ADRC Date: