Date of Admission:
June 2, 2008
Date of Discharge:
June 1, 2011

DOEA NURSING HOME TRANSITION PLAN

Plan Development Date: 01/01/2011 Anticipated Waiver: ☒ ADA ☐ ALE
Actual Waiver & Enrollment Date: ADA 06/01/2011

A. DEMOGRAPHIC

1. Consumer Name: Jane Smith
2. SSN and/or Medicaid Number: 123-45-6789 1234567890
3. Referral Date (NHTR Start): 12/24/10
4. Facility Name/Address: ACME Nursing Home 123 Main St. Minneola, FL 12345
5. Facility Contact (Name & Phone): John Brown 000-555-5555
6. Primary Contact: ☒Client/☐ Representative (Name & Phone): Ralph Smith 000-444-4444
7. Relationship to Consumer: Husband
8. Planned Dwelling type: ☐ ALF ☐ w/Family ☒ Private Residence
9. Planned Community Address: 789 Piney Dr. Minneola, FL 12345
10. Financial Eligibility Packet Sent to DCF? ☒ Yes ☐ No Date Sent: 12/30/10
11. Case Management Agency: ABC Agency
12. Transition Case Manager (Name & Phone): Denise Waters 555-555-6789

B. TRANSITION PLAN DEVELOPMENT PARTICIPANTS:

1. Name: Ralph Smith
Relationship: Husband
Phone: 000-444-444 Address: 789 Piney Dr. Minneola, FL 12345

2. Name: Lara Croft
Relationship: Daughter
Phone: 000-333-3333 Address: 4321 Campbell St. Minneola, FL 12345

3. Name:
Relationship:
Phone: Address:

4. Name:
Relationship:
Phone: Address:

C. GOALS & POTENTIAL BARRIERS TO TRANSITION

1. Goal: Return to her home with her husband.

Barrier: Due to a stroke, Mrs. Smith experiences right side paralysis and her husband is physically unable to assist her with ADLs.

Support needed to remove barrier: Assistance with bathing.

Who is providing the support: ABC Agency and Lara Croft

Estimated timeframe of resolution: 06/01/2011

Progress Notes/Updates:
Transition case manager will process referral to ABC Agency. ABC Agency will provide personal care twice a week and Ms. Croft will provide assistance when ABC Agency is not.
Follow-up: Visit w/client and Mr. Smith to inform them that they are Medicaid eligible and services from ABC will be in place on 06/01/11.

2. Goal: Attend occupational & physical rehabilitative therapy as prescribed.

Barrier: Mr. Smith does not drive.

Support needed to remove barrier: Assistance in locating affordable transportation service and coordination of appointments with transportation provider.

Who is providing the support: The Smiths are members of a church located near their home that provides local transportation for short trips at no cost for members.

Estimated timeframe of resolution: 01/07/11

Progress Notes/Updates:
Mr. Smith will contact the transportation coordinator at the church to make arrangements for the appointments already scheduled.
Follow-up: Mr. Smith has reserved the church van for Mrs. Smith's appointments throughout the end of November as therapy appointments cannot be scheduled that far in advance.

3. Goal: Return to her home with her husband.

Barrier: Bathrooms in home are not equipped with grab bars.

Support needed to remove barrier: Grab bars installed on date of discharge by home modification provider.

Who is providing the support: ABC Agency

Estimated timeframe of resolution: 06/01/2011

Progress Notes/Updates:
Transition case manager will arrange for ABC Agency to meet client at home on date of discharge for installation of grab bars.
Follow-up: On 06/01/11, follow up with client to ensure provider has installed grab bars.

Time Spent Plan Development: 1.5 hour

D. TRANSITION ASSISTANCE NEEDED

Transition Plan Services to start on discharge date:

Provider	Service (ND = Non-DOEA Services) (MW = Waiver Services)	Frequency	Cost
ABC Agency	*Personal Care (MW)*	1 hour 2x per week	$72.00
Family Support (Lara Croft)	Personal Care (ND)	1 hour 5x week	0.00
Church	Transportation (ND)	2 trips per week	0.00
ABC Agency	Home Modifications (MW)	1 installation	$75.00

Close out notes:

Visit with Mr. & Mrs. Smith to ensure that all services were in place and ready for Mrs. Smith's discharge on June 1, 2010. Transition case manager's final visit for the NHTR participants to sign Transition Plan.

Time Spent Plan Development: 30 mins.

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:

Jane Smith _____ 01/11/2011

Signature-Consumer/Representative Date

Denise Waters _____ 01/11/2011

Signature-Transition Case Manager Date

TRANSITION BILLING:

Total Time for Transition: 120 mins Total Units for Transition: 8 (15 min. increments) ☒ CIRTS updated

Copies of plan sent to: ☒ Individual Date: 06/01/11 ☒ CARES Date: 01/11/11

☐ ARC/ADRC Date: