



INDIVIDUALIZED TRANSITION PLANS



Participant Name: _____

Pre-Transition Individualized Transition Plan (Pre-ITP)

1. MFP PARTICIPANT INFORMATION

Participant First Name: _____ MI: __ Last Name: _____

Date of Birth (mm/dd/yyyy) _____ SSN: _____ - _____ - _____

Medicaid ID # _____ Medicare # _____

Inpatient Facility Name and Address: _____

City, Zip and County: _____

This is an (check only one): Initial Pre-ITP –OR-- Updated Pre-ITP Date: _____

2. IMPORTANT PLANNING DATES

Projected Discharge/Move-out Date: _____ Actual Discharge/Move-out Date: _____

3. HOUSING CHOICE/LIVING ARRANGEMENTS

Check if participant will live with family. Name _____

Address _____

City _____ ST _____ ZIP _____

Check if participant has someone that she/he wants to live with.

Name _____

Contact Phone _____ Other Phone _____

Check the housing choice expressed by the participant/family. Is housing choice needed?

Check Housing Choice	Participant / Family Has? Y/N	Participant / Family Needs? Y/N
<input type="checkbox"/> 01- Home owned by participant		
<input type="checkbox"/> 02- Home owned by family member		
<input type="checkbox"/> 03- Apt/house leased by participant, not assisted living		
<input type="checkbox"/> 04- Apartment leased by participant, assisted living		
<input type="checkbox"/> 05- Group home of no more than 4 people/ PCH		

Note: If participant has living arrangements in place, go to Q4 Health and Nutrition. If “Participant/Family Needs” is marked “Y”, describe problem/issue, strategies for resolving and tasks that must to be done to secure choice:

(Continue narrative on back or add additional pages as needed)

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4. HEALTH AND NUTRITION GOALS:

List Health Related Needs	Who can help? What resources are available to help?	Health Improvement Goal

Ex: Rx med supply, specialized medical supplies, skin care/wounds, bowel/bladder program, etc.

List Nutrition Related Needs	Who can help? What resources are available to help?	Nutrition Improvement Goal

Ex: diet and restrictions, food preferences, preparation strategies, food supplies, etc.

5. 24/7 EMERGENCY BACKUP PLANS:

List Risks to Health/Safety	Describe Plan to Address Risk	Emergency Backup Plan

Ex: natural disasters, power outages, PSS doesn't show up, equipment failures, falls/injuries, etc.

6. OTHER ISSUES (Unique to Participant and Necessary for Discharge)

Goal/Issue	Barriers/Needs	Plan/Resource

(Continue narrative on back or add additional pages as needed)

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PRE-TRANSITION PLAN ASSIGNMENTS:

Assignment	Person Responsible	Projected Date of Completion	Actual Date of Completion

Recommended Assignments: Who will assist with the following -

- Conduct Housing Searches; Arrange Environmental Modifications/Home Inspections
- Arrange Community Transportation Services/Travel Training
- Resolve Legal Issues
- Arrange Peer Support/Independent Living Skills Training/Life Skills Coaching
- Arrange Counseling/Behavioral Health Needs
- Schedule Home Care Ombudsman Visits; Arrange Caregiver Outreach and Training
- Locate Community Pharmacy for Refills of Rx Medications
- Locate Primary Care Physician/Clinic; Schedule Medical/Dental/Specialist Appointments
- Complete Waiver Enrollment; Select Case Mgt/Care Coordinator, Service Providers
- Complete Quality of Life Survey
- Referrals for Durable Medical Equipment and Assistive Technology

PRE-ITP TEAM SIGNATURE PAGE (signatures of persons who assisted in development of the Pre-ITP)

Print Name/Title or Relationship	Signature

Field Personal Contact

Name: _____ Date: _____

Phone: _____ Email: _____

(Continue narrative on back or add additional pages as needed)

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Participant Name: _____

Post Discharge-Individualized Transition Plan- Post-ITP

(Must be completed within first 30 days post discharge)

1. MFP PARTICIPANT INFORMATION

Participant First Name: _____ MI: __ Last Name: _____

Date of Birth (mm/dd/yyyy) _____ SSN: _____ - _____ - _____

Medicaid ID # _____ Medicare # _____

Address: _____

City, Zip and County: _____

Discharge Date (mm/dd/yyyy): _____ Moving Date: _____

2. Waiver Name _____

Waiver Case Manager/Care Coordinator Name _____

CM/CC Phone _____ Email _____

3. HOUSING CHOICE AT DISCHARGE

Check Housing Type at Discharge	Problems/Comments
<input type="checkbox"/> 01. Home owned by participant	
<input type="checkbox"/> 02. Home owned by family member	
<input type="checkbox"/> 03. Apartment leased by participant, not assisted living	
<input type="checkbox"/> 04. Apartment leased by participant, assisted living	
<input type="checkbox"/> 05. Group home of no more than 4 people/ PCH	

Notes:

4. PERSONAL GOALS/ DESIRED COMMUNITY OUTCOMES

Personal Goals/ Desired Community Outcomes	Barriers to Achieving Goals/Needs	Plan/Resources for Barrier Removal

Notes:

(Continue narrative on back or add additional pages as needed)

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5. SENSORY/COMMUNICATION GOALS

Includes – vision, hearing, dental, mobility, speech/language and general communication goals.

Sensory/Communication Goals	Barriers to Achieving Goals/Needs	Plan/Resources for Barrier Removal

6. SOCIAL/RECREATIONAL GOALS

Activity Goals	Barriers/Needs	Plan

7. HOUSEHOLD/PERSONAL CARE GOALS (from Screening - Q34/DON-R)

Goals	Barriers/Needs	Plan

(Continue narrative on back or add additional pages as needed)

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8. ASSISTIVE TECHNOLOGY (AT) AND/OR DURABLE MEDICAL EQUIPMENT (DME) USE AND NEEDS (from Screening, use Q32 and Q33)

Assistive Tech/DME Needs	Who can help/Resources?	Plan (who does what)

9. COMMUNITY ACCESS/TRANSPORTATION GOALS

Goals	Barriers/Needs	Plan

10. EMPLOYMENT GOALS – supported, customized, competitive and/or self-employment or volunteer/work without pay (complete if applicable)

Goals	Barriers/Needs	Plan

(Continue narrative on back or add additional pages as needed)

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11. OTHER ISSUES (Unique to Participant and Necessary for Successful Transition)

Goals/Issues	Barriers/Needs	Plan/Resources

12. INCOME and RESOURCES – Create a budget for community living

Budget Categories	Monthly Amounts/Costs	Notes
Monthly Income (all sources)		
Housing (rent, utilities) costs		
Food costs		
Debts		
Medical, health care, prescription drugs costs		
Personal items, movies, entertainment costs, etc.		
Transportation costs		
Other		
Other		
Other		

(Continue narrative on back or add additional pages as needed)

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POST-DISCHARGE TRANSITION PLAN ASSIGNMENTS:

Assignment	Person Responsible	Projected Date of Completion	Actual Date of Completion

Recommended Assignments: Who will assist with the following -

- Conduct Housing Searches; Arrange Environmental Modifications/Home Inspections
- Arrange Community Transportation Services/Travel Training
- Resolve Legal Issues
- Arrange Peer Support/Independent Living Skills Training/Life Skills Coaching
- Arrange Counseling/Behavioral Health Needs
- Schedule Home Care Ombudsman Visits; Arrange Caregiver Outreach and Training
- Locate Community Pharmacy for Refills of Rx Medications
- Locate Primary Care Physician/Clinic; Schedule Medical/Dental/Specialist Appointments
- Complete Waiver Enrollment; Select Case Mgt/Care Coordinator, Service Providers
- Complete Quality of Life Survey
- Referrals for Durable Medical Equipment and Assistive Technology

POST- ITP TRANSITION TEAM SIGNATURE PAGE (signatures of persons who assisted in development of the Post-ITP)

Print Name/Title or Relationship	Signature

MFP Field Personal Contact

Name: _____ Date: _____

Phone: _____ Email: _____

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