



MFP Discharge Day Checklist

Revised 061112



OC/TC/PLA/CE Name/Phone #:			Date:
MFP Participant Information			
Name:			Date of Birth:
New Address:			Phone Number
City:	Zip:	County:	Change Of Address Notification To: <input type="checkbox"/> DFCS <input type="checkbox"/> Social Security <input type="checkbox"/> Other(Please List)
<input type="checkbox"/> Home owned by Participant <input type="checkbox"/> Home owned by Family Member <input type="checkbox"/> Apartment Leased by Participant, Not Assisted Living <input type="checkbox"/> Apt. Leased by Participant, Assisted Living <input type="checkbox"/> Group Home of No More Than 4 People/PCH <input type="checkbox"/> Lives with family (check for yes)			
Individualized Transition Plan (ITP)			
Item Key: N=Needed; O=Ordered; S = Secured; N/A=Not Applicable			
Items (provide items for all that apply):			
___ Home: ___ Modifications; ___ Security Deposit; ___ Utility Deposits: _____; ___ Other: _____			
___ Household items: ___ Kitchen: _____; ___ Bath: _____; ___ Bed: _____			
___ Food & Nutrition: _____			
___ Health & Hygiene: _____			
___ RX Medications _____			
___ Medical Services/DME Equipment: _____			
___ Assistive Technology Devices: _____			
___ Life Skills/ Socialization: _____			
___ Financial: _____			
___ Transportation: _____			
___ Other:(list) _____			
Waiver:	Waiver Case Manager/Care Coordinator/Planning List Admn:		Phone:
Waiver services ordered at discharge: _____; _____; _____; _____; _____; _____;			
Are providers identified to begin services upon discharge?: <input type="checkbox"/> Yes <input type="checkbox"/> No* If no, explain:			
Name of Community Pharmacy:			
24/7 Emergency plan reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No* If no, explain:			
Please identify participant's needs upon discharge and the plan to meet the participant's need: (attach additional sheets as needed)			
Follow-up Visits/Quality Management			
Home Visits: Please provide schedule for follow up visits.			
<input type="checkbox"/> Transition Coordinator: 1 st Scheduled Visit: _____; 2 nd Scheduled Visit: _____			
<input type="checkbox"/> Waiver Case Mgr /Care Coord/Support Coord/PLA Name: _____ Phone: _____			
1 st Scheduled visit: _____; 2 nd Scheduled Visit: _____			
<input type="checkbox"/> Community Ombudsman Name: _____ Phone: _____ Email: _____			
1 st Scheduled F2F visit (or n/a): _____; 2 nd Scheduled F2F Visit: _____			
<input type="checkbox"/> County DFCS Office Contact: _____ Phone: _____ Email: _____			
Quality of Life Survey: <input type="checkbox"/> Initial; <input type="checkbox"/> 2 nd Survey; <input type="checkbox"/> Completed: <input type="checkbox"/> Scheduled: <input type="checkbox"/> Rescheduled: _____			
Participant Tracking			
<input type="checkbox"/> This report sent to DCH/MFP Office by secure email to gamfp@dch.ga.gov attention: _____ <input type="checkbox"/> This report faxed to client's Case Manager/Care Coordinator			Date:
By: _____		Title: _____	