



North Carolina Money Follows the Person Transition Plan

Transition Planning Group	
Participant's Name and Contact Information	
Representative's (if applicable) Name and Contact Information and Relationship	
Other Friends/Family:	
Transition Coordinator Contact Information:	
Transition Coordinator's Name and Contact Information:	
Facility Name and Contact Person's Information	
Others:	

COUNTY INFORMATION

Medicaid County: _____

County Currently Residing In: _____

County Moving To: _____

Will Medicaid be Transferred?

TRANSITION INFORMATION

Date Initial Transition Planning Meeting Held:

Date Final Transition Planning Held:

Estimated Transition Date:

WHY THIS MATTERS TO ME

What am I looking forward to about transitioning into my own home/community?

My History: Why I Came to the Facility in the First Place:

My Future: What I'm Looking Forward to About Being in my Home and Community:

WHERE I WILL LIVE

<p>I do/do not have a home (own or family's) to return to (circle one).</p>	<p>If not secured, what is preliminary plan for developing? Who will take the lead?</p>	<p>Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.).</p>
<p>If no, my housing needs related to:</p> <ul style="list-style-type: none"> • affordability • accessibility • rent • utility • deposits needed <p>List Here:</p>		
<p>Basic household safety needs (fire extinguisher, smoke detectors, etc.):</p> <p>List here:</p>		
<p>Other:</p>		

MY MEDICAL SUPPORTS

My Community-Based Medical Needs	If not secured, what is preliminary plan for developing? Who will take the lead?	Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.)
I will enroll in Community Care of North Carolina (please circle one): Yes or No		
My doctor will be:		
Needed Specialists:		
My dentist will be:		
My pharmacist will be:		
Other		
Strategy for ensuring continuity of care between facility and community-based medical services. (i.e. Ensuring sufficient medication is available./prescriptions are in place, etc.)		
Type of assistance needed with medications.		

MY ADAPTIVE EQUIPMENT NEEDS

I do/do not have adaptive equipment needs. (circle one)	If not secured, what is preliminary plan for developing? Who will take the lead?	Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.)
Mobility (wheelchair, walker, etc.)		
Home modifications		
Independence Aids		
Use of In-home monitoring (Simply Home, Rest Assured, Life Line)		
Adaptive Supplies (modified dishes, gait belts, etc.)		

MY MENTAL HEALTH/BEHAVIORAL SUPPORT NEEDS

I do/do not have mental health, substance addiction or behavioral support needs (circle one).	If not secured, what is preliminary plan for developing? Who will take the lead?	Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.)
Is there a current behavior support plan in place if needed?		
Linked with NC-Start (if applicable)		Amount of support confirmed to be provided:
Linked with community-based psychiatrist (if needed)		Amount of support confirmed to be provided:
Linked with community-based psychologist (if needed)		Amount of support confirmed to be provided:
Special staff training (as needed)		
Linked with the appropriate substance addiction support services if needed.		

WHAT I NEED TO FEEL SAFE IN MY HOME and COMMUNITY

<p>Safety</p>	<p>If not secured, what is preliminary plan for developing? Who will take the lead?</p>	<p>Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.).</p>
<p>What I Need to Feel Safe</p>		
<p>How I will get out in a fire in the middle of the night</p>		

MY MONEY

<p>My Income</p>	<p>If not secured, what is preliminary plan for developing? Who will take the lead? Does it need to transfer?</p>	<p>Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.).</p>
<p>Where Will I Bank When I Move?</p>		
<p>Supplemental Security Income:____ Monthly Amount:</p>		
<p>Social Security Disability Income____ Monthly Amount</p>		
<p>Other Income?____ Monthly Amount:</p>		
<p>Will I have a Medicaid deductible?</p>		
<p>Am I Eligible for Food Stamps?</p>		
<p>Am I Eligible for Other Support Services?</p>		
<p>What personal documents do I need to secure? ___ State issued ID ___ Social Security Card ___ Birth Certificate ___ Other</p>		
<p>Plan for Ensuring Benefits Transfer from Facility</p>		

HOW I'LL GET AROUND IN MY COMMUNITY

	If not secured, what is preliminary plan for developing? Who will take the lead?	Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.).
Will I have access to public transportation?		
Do I need accessible transportation?		
How will I get to community-based activities and appointments?		

BEING INVOLVED IN MY COMMUNITY

	If not secured, what is preliminary plan for developing? Who will take the lead?	Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.).
<p>I do/do not (circle one) want to work for pay.</p> <p>I do/do not want (circle one) to explore continuing education opportunities.</p>		
<p>How will I spend my day in a way that provides the support, social opportunity and structure I want and need?</p>		
<p>I do/do not (circle one) have friends and family where I'm moving to.</p>	<p>If no, what are the plans for supporting me to build community?</p>	
<p>I do/do not (circle one) want to be connected to a peer mentor.</p>		
<p>I do/do not want to be connected with other people in my area who are supporters of MFP and of building inclusive communities.</p>		
<p>These are the people I would like to remain in contact with once I leave the facility.</p> <p>These are some of the people in my community, I'd like to reconnect with once I return home:</p>		

MY SCHOOL

I am/am not (circle one) school aged.	If not secured, what is preliminary plan for developing? Who will take the lead?	Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.).
Name and contact information for the school I will be attending.		
The particular supports, devices, or therapies that I need to attend school are:		
Has there been an IEP meeting scheduled? If so, what is date?		

MY STAFF

	If not secured, what is preliminary plan for developing? Who will take the lead?	Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.).
I would like to help select the staff who are working with me. Yes ___ No ___		
How my staff will be trained:		
What are the important things that need to be included in my staff's training?		
Will my staff visit/train with me before I transition?		

MY FAMILY/SUPPORT NETWORK

	<p>If not secured, what is preliminary plan for developing? Who will take the lead?</p>	<p>Finalized Plan and Contact Information (i.e. address of apartment, doctor's name, etc.).</p>
<p>How will my family or friends participate in my supports?</p>		
<p>If I am going home to my family, we do/ do not (circle one) want to try a homestay before transitioning.</p>		
<p>Do these family members want information about caregiver support options?</p>		
<p>Do these family members/friends understand respite options available?</p>		
<p>Other family-specific considerations.</p>		

OUR BACK UP PLANS

IF....	WE WILL
If natural supports become worn out....	
If the staff don't show up....	
If we realize we need more paid services:	
If a provider discontinues services:	
If there is a medical emergency:	
Other Person-Specific Contingency Plans: If...	

THE FINAL PAGE

Other “To Dos” Not Otherwise Listed:

Staying In Touch

How often do we want to connect (by phone/email/conference call)

When do we need to meet in person again?

Will we be accessing MFP’s Transition Year Stability Resources?

List Needs Here:

Have we contacted Project for latest TYSR Protocol?

Have we submitted requests?

Date Preliminary Plan Submitted to MFP: _____ **Date Final Plan Submitted to MFP:** _____

Transition Coordinator’s Signature on Final Plan Submitted to MFP: _____