

## In-Reach/Transitions to Community Living Tool

This tool is to be started from the first contact with an individual whether it is during the In Reach or Diversion process and then follow that individual until they are successfully transitioned into the community or withdrawn from the TCL initiative.

**Please fill in all areas completely and if information is not applicable put N/A.**

<b>SECTION A. DEMOGRAPHICS</b>					
<b>1. Participant Data</b>					
First Name:		Last Name:			
Alpha ID#		DOB:			
Street Address:		City,State,Zip			
Phone:	#1		#2		
Medicaid County		Medicaid #		County of Residence	
<b>2. Guardian/Authorized Rep Data</b>					
Is there a Guardian/Rep?	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>				
If yes - relationship:					
First Name:		Last Name			
Street Address:		City,State,Zip			
Phone	#1		#2		
<b>3. Emergency Contact Data:</b>					
First Name		Last Name			
Street Address:		City,State,Zip			
Phone	#1		#2		
<b>Other Friends/Family</b>					
Name	Relationship	Address	Phone #1	Phone #2	
<b>4. Payee Contact Data</b>					
Payee	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>				
First Name	Click here to enter text.	Last Name	Click here to enter text.		
Phone	#1 Click here to enter text.	#2	Click here to enter text.		

<b>5. In Reach Staff Data</b>			
<b>First Name</b>	Click here to enter text.	<b>Last Name</b>	Click here to enter text.
<b>Phone</b>	#1 Click here to enter text.	#2	Click here to enter text.
<b>6. Facility Name and Contact Information</b>			
<b>Name</b>	Click here to enter text.		
<b>Contact Name</b>	Click here to enter text.		
<b>Street Address:</b>	Click here to enter text.	<b>City, State, Zip</b>	Click here to enter text.
<b>Phone</b>	#1 Click here to enter text.	#2	Click here to enter text.
<b>7. Transition Coordinator Data</b>			
<b>First Name</b>	Click here to enter text.	<b>Last Name</b>	Click here to enter text.
<b>Phone</b>	#1 Click here to enter text.	#2	Click here to enter text.
<b>8. Clinical Care Coordinator Data</b>			
<b>First Name</b>	Click here to enter text.	<b>Last Name</b>	Click here to enter text.
<b>Phone</b>	#1 Click here to enter text.	#2	Click here to enter text.
<b>9. Current Living Situation:</b>	<input type="checkbox"/> Private Residence (Owned, rented or leased by individual/family <input type="checkbox"/> Owned <input type="checkbox"/> Rented <input type="checkbox"/> Alternative Family Living (AFL) <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Other Click here to enter text. <input type="checkbox"/> 5600 Licensed Group Home		

**SECTION B: ONE PAGE PROFILE**

*(SEE IN REACH/TRANSITIONS TO COMMUNITY LIVING CONVERSATIONAL GUIDANCE DOCUMENT)*

**SECTION C: MY/OTHERS PERSPECTIVE**

*(SEE IN REACH/TRANSITIONS TO COMMUNITY LIVING CONVERSATIONAL GUIDANCE DOCUMENT)*

<b>SECTION D: This is the kind of help I think I would need to live in my ideal living situation: Date Updated</b>				
	<b>Consumer's perspective</b>	<b>Staff's perspective</b>	<b>Explain if assistance of any kind is required:</b>	<b>Consumer's assessment of potential risk if this area is not addressed:</b>
Assistance with medications: remembering to take it, education around, etc.	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with physical needs: adaptive equipment, vision or hearing related supports, in home supports	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with health risks related to medical concerns: complications from diabetes etc.	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with activities of daily living (bathing, dressing, mobility, toileting, eating etc.)	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with crisis management (ability to contact support professionals)	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with maintaining my home (housekeeping skills...)	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with meal preparation	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with paying household bills and money management	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with understanding tenant/landlord rights and responsibilities	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with connecting to family, friends, and community connections	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with employment/meaningful activities	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with how I want to spend my time	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		

Assistance motivating myself to do what I want to do or know I need to do	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with transportation	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		
Assistance with safety	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance	<input type="checkbox"/> No help <input type="checkbox"/> Minor <input type="checkbox"/> Full assistance		

**SECTION E: A GOOD WEEK OF MEANINGFUL DAYS**

(SEE IN REACH/TRANSITIONS TO COMMUNITY LIVING CONVERSATIONAL GUIDANCE DOCUMENT)

SECTION F: MEDICAL AND MENTAL HEALTH INFORMATION			
<b>Doctor # 1 PCP</b>		<b>Date Updated:</b>	
a. Doctor's name			
b. Practice Name			
c. Street Address:		d. City, State, Zip	
e. Phone	#1	#2	
f. Why I see this doctor			
<b>Doctor # 2</b>		<b>Date Updated:</b>	
a. Doctor's name			
b. Practice Name			
c. Street Address:		d. City, State, Zip	
e. Phone	#1	#2	
f. Why I see this doctor			
<b>Doctor # 3</b>		<b>Date Updated:</b>	
a. Doctor's name			
b. Practice Name			
c. Street Address:		d. City, State, Zip	
e. Phone	#1	#2	
f. Why I see this doctor			

<b>Doctor # 4</b>		<b>Date Updated:</b>	
a. Doctor's name			
b. Practice Name			
c. Street Address:		d. City, State, Zip	
e. Phone		#1	#2
f. Why I see this doctor			
<b>Doctor # 5</b>		<b>Date Updated:</b>	
a. Doctor's name			
b. Practice Name			
c. Street Address:		d. City, State, Zip	
e. Phone		#1	#2
f. Why I see this doctor			

<b>CURRENT HEALTH ISSUES</b>					
1.	Medical Issue/Condition – Date Updated:	Medication Prescribed	Date of Onset	Doctor/Practice Treating Issue	Client Perception of Severity of Condition
a.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
b.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
c.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
d.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
e.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
f.		<input type="checkbox"/> Yes <input type="checkbox"/> No			

2.	Mental Health Issue/Condition – Date Updated:	Medication Prescribed	Date of Onset	Doctor/Practice Treating Issue	Client Perception of Severity of Condition
a.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
b.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
c.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
d.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
e.		<input type="checkbox"/> Yes <input type="checkbox"/> No			
f.		<input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>PHARMACY INFORMATION</b>			
<b>Pharmacy Information</b>		<b>Date Updated:</b>	
<b>Pharmacy Name:</b>			
<b>Street Address:</b>		<b>City, State, Zip</b>	
<b>Phone:</b>		<b>#1</b>	<b>#2</b>
<b>Pharmacy Information</b>		<b>Date Updated:</b>	
<b>Pharmacy Name</b>			
<b>Street Address:</b>		<b>City, State, Zip</b>	
<b>Phone</b>		<b>#1</b>	<b>#2</b>
<b>Pharmacy Information</b>		<b>Date Updated:</b>	
<b>Pharmacy Name</b>			
<b>Street Address:</b>		<b>City, State, Zip</b>	
<b>Phone</b>		<b>#1</b>	<b>#2</b>

Known Allergies	Reaction

MEDICATIONS - Date Updated:						
List Medications (including supplements and over the counter)	Prescribed for condition # above	Dose	Frequency	Date prescribed	Prescribing Physician	Pharmacy
a.						
b.						
c.						
d.						
e.						
f.						
g.						
h.						
i.						

**SECTION G: OTHER INFORMATION THAT IS IMPORTANT TO KNOW ABOUT ME**

**SECTION H: SIGNATURES**

<b>Signature</b>	<b>Date</b>	<b>Relationship</b>

**Updates/Revisions**

<b>Signature</b>	<b>Date</b>	<b>Relationship</b>