Date of Admission:
June 2, 2008
Date of Discharge:
Unsuccessful

DOEA NURSING HOME TRANSITION PLAN

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

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): Carla Wilson 000-444-4444
7. Relationship to Consumer: Daughter
8. Planned Dwelling type: ☐ ALF ☐ w/Family ☒ Private Residence
9. Planned Community Address: HUD: 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 000-555-5555

B. TRANSITION PLAN DEVELOPMENT PARTICIPANTS:

1. Name: Carla Wilson
Relationship: Daughter
Phone: 000-444-444 Address: 500 Manhattan Dr. #3, New York, NY 70145

2. Name:
Relationship:
Phone: Address:

3. Name:
Relationship:
Phone: Address:

4. Name:
Relationship:
Phone: Address:

C. GOALS & POTENTIAL BARRIERS TO TRANSITION

1. Goal: Move into an apartment from the nursing home with roommate or other community support.

Barrier: Needs personal care, chore, homemaker, home-delivered meals, and escort services due to right side paralysis resulting from a stroke 2 years ago. Prior to nursing home placement over 2 years ago, Ms. Smith shared an apartment with a roommate and split the rent. Since that time, her roommate has passed away and the apartment was leased to someone else. She does not want to live in an ALF environment and prefers to live in an apartment on her own. She needs maximum assistance with all of her activities of daily living and may need additional community support to transition.

Support needed to remove barrier: Waiver services as listed above, assistance identifying additional community support, and a Housing and Urban Development (HUD) referral.

Who is providing the support: ABC Agency will provide waiver services identified in the client's anticipated care plan. Transition case manager discussed options for locating additional community support, including client suggestion that someone at her former church may be interested in moving into a shared apartment with her. The transition case manager provided Ms. Smith with the contact information for HUD. Transition case manager will follow up with the client to provide additional assistance as needed and see if progress was made to remove transition barriers.

Estimated timeframe of resolution: Prior to anticipated discharge date of 06/01/11

Progress Notes/Updates:

01/15/2011 – Ms. Smith is still unable to perform ADLs due to stroke. Although she reports improvement, if she were to return to the community, she would need maximum assistance with all ADLs and per client's preference a roommate or live-in caregiver. Client indicates she will call HUD directly or ask her daughter to help find an apartment. The transition case manager offered to contact the daughter if needed, and will follow-up with client's progress in one week.

Follow-up:

01/22/2011 – Transition case manager received phone call from Ms. Smith stating she spoke with coordinator from HUD facility who informed her it takes an average of two years before a unit becomes available to a person applying that day. Ms. Smith is working with her daughter to submit an application. Ms. Smith stated she also reviewed an apartment rental guide, but all of the units were just above her income and would require a security deposit. She does not have any savings at this time and has been unable to find a roommate or other community support through her church, friends, or family. Transition case manager explained to Ms. Smith that in order to safely transition into the community, she will need housing and additional support. Client indicated she was unsure if she would be able to move into her own apartment soon, but would like to keep her options open and hopes housing might be available soon. The transition case manager made an appointment to meet with Ms. Smith on January 20, 2011 in order to sign off on the nursing home transition plan.

2. Goal:

Barrier:

Support needed to remove barrier:

Who is providing the support:

Estimated timeframe of resolution:

Progress Notes/Updates:

Time Spent Plan Development: 2 hours

D. TRANSITION ASSISTANCE NEEDED

Transition Plan Services to start on discharge date:

Provider	Service (ND = Non-DOEA Services) (MW = Waiver Services)	Frequency	Cost
HUD Agency	Housing Referral (ND)	1x	$0.00
ABC Agency	Personal Care (MW)	1 hour 7x a week	$560.00/month
ABC Agency	Chore (MW)	1 hour 1x week	$72.00/month
ABC Agency	Homemaker (MW)	1x month	$18.00/month
ABC Agency	Home Delivered Meals (MW)	7 meals 7x week	$196.00/month
ABC Agency	Escort Services (MW)	1 hour 4x a month	$84.00/month
Total			$930/month

Close out notes:

Transition case manager traveled to nursing home to finalize NHT plan. Although Ms. Smith understands why she is unable to transition at this time, she plans to stay on waitlist for HUD housing. She has the contact information for CARES and the transition case manager if her situation changes. The transition case manager is forwarding this transition plan to local CARES office for CARES to review and send due process notification as required.

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. Client unable to find housing in the community.

2. Client requires additional community support but has not located necessary support at this time.

Time Spent Plan Development: 30 min

Jane Smith_____ __1/20/11____

Signature-Consumer/Representative Date

Denise Waters_____ ___1/20/11____

Signature-Transition Case Manager Date

TRANSITION BILLING:

Total Time for Transition: Total Units for Transition: ☒ CIRTS updated

Copies of plan sent to: ☒ Individual Date: 1/20/11 ☒ CARES Date: 1/20/11

☒ ARC/ADRC Date: 1/20/11