DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Person-Centered Transition Plan Form

Name: | Date of Assessment:

Address: | Date of Birth:

City, State, Zip Code: | Preferred Language:

Email Address: | Authorization Period:

Primary Care Provider: | Phone:

Waiver Case Manager: | Phone:

Regional Transition Coordinator: | Phone:

Description of Services: *Identify any devices/technology the individual currently uses and how they are maintained in the community. If more space is needed, attach a separate sheet.*

1. Device/Assistive Technology (wheelchair, walker, oxygen, etc..): | Provider (if applicable):

Frequency of use (daily, weekly, only for transportation, etc.): | Assistance needed (reordering, maintenance, etc.):

Medical order is current: YES ◯ NO ◯ | Assistance provided by:

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2. Device/Assistive Technology (wheelchair, walker, oxygen, etc..): | Provider (if applicable):

Frequency of use (daily, weekly, only for transportation, etc.): | Assistance needed (reordering, maintenance, etc.):

Medical order is current: YES ◯ NO ◯ | Assistance provided by:

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3. Device/Assistive Technology (wheelchair, walker, oxygen, etc..): | Provider (if applicable):

Frequency of use (daily, weekly, only for transportation, etc.): | Assistance needed (reordering, maintenance, etc.):

Medical order is current: YES ◯ NO ◯ | Assistance provided by:

Person-Centered Transition Plan Form

Independent Living Skills: *Identify any skills needed to ensure independence.*

Do you need assistance with establishing and maintaining a monthly budget?	YES ◯	NO ◯
Do you need independent living skills training in this area?	YES ◯	NO ◯
Have you coordinated a plan to purchase, cook, and eat meals?	YES ◯	NO ◯
Who will do the initial shopping for groceries and supplies?		
Do you need independent living skills training in this area?	YES ◯	NO ◯
Have essential household goods been identified as a need?	YES ◯	NO ◯
Do you need assistance with delivery or setup of household items?	YES ◯	NO ◯
Do you have any clothing needs?	YES ◯	NO ◯
What is the current status of your Medicaid (active, pending, etc.)?		
Do you need an assistive technology assessment?	YES ◯	NO ◯
If an assessment determines you have an assistive technology need, do you have a funding source to purchase the equipment?	YES ◯	NO ◯
If you have an assistive technology need, do you need training on how to use the equipment?	YES ◯	NO ◯
Have you experienced any falls in the last 12 months?	YES ◯	NO ◯
Do you feel unsteady when standing or walking?	YES ◯	NO ◯
Do you worry about falling?	YES ◯	NO ◯

Person-Centered Transition Plan Form

Unmet Service Needs: *Identify any services or household goods needed. If more space is needed, attach a separate sheet.*

Service Need:

Justification of Service:

Plan to Address Need:

Service Need:

Justification of Service:

Plan to Address Need:

Service Need:

Justification of Service:

Plan to Address Need:

Informal Supports: *Identify unpaid supports and their relationship to the person. If more space is needed, attach a separate sheet.*

Name: Phone:

Relationship/Title:

Service Provided/Support Role:

Frequency of Contact:

Name Phone:

Relationship/Title

Service Provided/Support Role

Frequency of Contact

Name Phone:

Relationship/Title

Service Provided/Support Role

Frequency of Contact

Person-Centered Transition Plan Form

Housing: *Please complete the Housing Checklist for each individual and the ALF Selection Form where applicable.*

Have you reviewed your lease/rental agreement? YES NO

If needed, are you willing to move to a different community? YES NO

If so, what communities?

Have you placed your name on any waiting list for housing in which you would like to reside? YES NO

If so, which ones?

Assessment Information: *Include all applicable assessments (PT/OT, LOC, LOI, Falls Prevention, etc.). If more space is needed, attach a separate sheet.*

Assessment #1 Name:

Most Recent Assessment Date (Month/Year)	Date of Initial Assessment (Month/Year)	Anticipated Reassessment Date (Month/Year)

Assessment #2 Name:

Most Recent Assessment Date (Month/Year)	Date of Initial Assessment (Month/Year)	Anticipated Reassessment Date (Month/Year)

Assessment #3 Name:

Most Recent Assessment Date (Month/Year)	Date of Initial Assessment (Month/Year)	Anticipated Reassessment Date (Month/Year)

Assessment #4 Name:

Most Recent Assessment Date (Month/Year)	Date of Initial Assessment (Month/Year)	Anticipated Reassessment Date (Month/Year)

Person-Centered Transition Plan Form

Risk Management and Safeguards: *Identify risks to the person's health/wellbeing, potential triggers, the person's previous responses to triggers, measures in place to minimize risks, and safeguards. Safeguards detail the support needed to keep the person safe from harm and actions to be taken when their health and welfare are at risk (please refer to guidance for more information).*

Risk:

Triggers:

Known response(s):

Measure(s) in place:

Safeguards:

Risk:

Triggers:

Known response(s):

Measure(s) in place:

Safeguards:

Backup Plan: *In the space below, describe the plan in place to ensure needed assistance will be provided if the regular services and supports in the individual's person-centered transition plan are temporarily unavailable. The backup care plan may include electronic devices, relief care, providers, other individuals, services, or settings. Individuals available to provide temporary assistance include informal caregivers such as a family member, friend, or another responsible adult. Include contact information as appropriate.*

Person-Centered Transition Plan Form

Self-Directed Services:

☐ I choose to self-direct some or all my services.

_____ may also act on my behalf to self-direct some or all my services.

This means I have the right to recruit, hire, fire, supervise, and manage my own staff. Alone, or with the help of my supports, I can choose the duties, schedules, and training requirements of my staff. This also includes the right to evaluate staff, decide their rate of pay, and review/approve payment requests. I will follow all laws and regulations when exercising these rights and responsibilities. The services I choose to self-direct are as follows:

Service #1: _____

Method of Self-Direction: SELF ☐ DESIGNATED REPRESENTATIVE ☐

Risk Management Techniques: _____

Process for Transitioning Out of Self-Direction: _____

Service #2: _____

Method of Self-Direction: SELF ☐ DESIGNATED REPRESENTATIVE ☐

Risk Management Techniques: _____

Process for Transitioning Out of Self-Direction: _____

Service #3: _____

Method of Self-Direction: SELF ☐ DESIGNATED REPRESENTATIVE ☐

Risk Management Techniques: _____

Process for Transitioning Out of Self-Direction: _____

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Person-Centered Transition Planning Process Information: *Complete the information below with meeting details as appropriate. Include signatures and information indicated in boxes below for all persons responsible for writing and implementing this plan.*

Meeting Date: Time:

Meeting Location:

Was this meeting held at a place and time of the person's choosing? YES ○ NO ●

Did the person lead the meeting to the best of their ability? YES ○ NO ●

Did the person choose who was at the meeting? YES ○ NO ○

Meeting Attendee's Name	Title/Relationship (Ex. RTC, CM, Provider, informal support, etc/)	Agency	Date

Acknowledgment: I have been a part of the person-centered transition planning process to the best of my ability. I agree with what is written in my plan.

Enrollee/Recipient or Designated Representative (Printed)

Enrollee/Recipient or Designated Representative Signature

5/29/25
Date

Regional Transition Coordinator (Printed)

Regional Transition Coordinator Signature

5/7/25
Date