Community Transitions Factsheet

Nursing Facility Name:

Client Name:			**Address:**			**Transition Date:**		
Client Phone#	**Home#**		**Cell#**		**Date of Birth:**		**Medicaid#**	
Medicaid Program:	**EPD Waiver Y / N**	**#Hours**	**State Plan Y / N**	**#Hours**	**Level of Care Start Date:**		**Level of Care End Date:**	
Client Self-Advocate	**Y / N**			**Legal Guardian/ Power of Attorney**				
Emergency Contact Info:	**1.**						**Phone#:**	
	2.						**Phone#:**	
Physician Info:	**Name:**			**Address:**			**Phone#:**	
Healthcare Decision Support	**1. Name**						**Phone#:**	
	2. Name						**Phone#:**	

Meeting Notes (describe identified transition support needs)

Case Management Agency: *(Notes should include acceptance date)*	
Home Health Agency: *(Notes should include acceptance date)*	
Other Waiver Service Agency/Provider: *(Notes should include acceptance date)*	
Other Waiver Service Agency/Provider: *(Notes should include acceptance date)*	
Non-Waiver Service Required: *(Notes should include acceptance date)*	
Skilled Nursing Care Support:	
Yes **No**	
Behavioral Health Provider / Support:	
Yes **No**	

Discharge/Community Transition Team Consensus. Place (x) in the applicable box to indicate participation approval.

	Beneficiary/AR/Guardian		**DHCF**		**DACL/CTT**		**HHA**
	Nursing Facility		**Case Management**		**Other**		**Other**

Service Type	**Start Date**	**Agency/Address**	**Contact Name/Agency Position**
Case Management:			
Home Health Agency:			
Skilled Nursing Care Support:			
Other Service Provider:			
Other Service Provider:			

DHCF/DACL Use Only

Completed/Updated by:		**Agency**		**Date:**	