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Transition Coordinator Name _____

Transition Coordinator Log

Initial Meeting(s)

1. Meeting Date(s) _____

2. Candidate's Name _____

3. Target Group: Elderly Person w/Physical Disability DD/MR

Date of Birth _____ Gender (circle): Male Female

Race/Ethnicity: (check all that apply)

American Indian/Alaskan Native

Asian/Pacific Islander

Black Not of Hispanic Origin

Hispanic

White Not of Hispanic Origin

Primary Spoken Language _____

Need a Translator/ Interpreter Present Yes No

4. Medicaid # _____

5. Facility Name _____

Facility Type: Hospital Nursing Facility ICF/MRc

Island _____

6. Persons Present (Include family, friends, guardian, facility staff)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

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Name _____ Relationship _____

7. Capable of self-consent? Yes _____ No _____

If no, who is responsible?

___ Family member responsible

___ Legal Guardian

___ Durable Power of Attorney

___ Other (explain) _____

8. Confirm eligibility

_____ Date of Entry into Facility

___ Medicaid for the last 30 days

___ In a facility for at least 6 months

_____ Date Eligibility Confirmed

9. Review Informational Materials (date as discussed)

_____ Brochure

_____ FAQs

_____ Rights and Responsibilities

_____ Success stories

10. Preference Interview

Consent to interview? Yes _____ No _____ Date _____

Completed interview? Yes _____ No _____ Date _____

Final preference? Yes _____ No _____ Don't Know _____

If no, reasons:

If don't know, reasons:

What would it take to change the person's mind?

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Other comments:

11. Informed Consent

_____(Date)- Read through informed consent and answered questions

Signed Informed Consent: Yes _____ No _____

If no, reasons:

12. Challenges

13. Special needs/ considerations

14. Follow-up

(e.g., talk with family members/guardians, talk with home health agency, set up next meeting)

Assessment and Care Planning Meeting(s)

15. Date(s) _____

16. Date that Assessment Completed _____

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17. Date that Care Planning forms Completed_____

18. Housing Challenges/Barriers:

19. Service Challenges/Barriers:

20. Concerns of Resident/ Family Members:

Social Support Available (List All Family and Friends Willing and Able to Provide At Least Some Level of Support When the Participant in the Community)

Name_____	Relationship_____
Name_____	Relationship_____
Name_____	Relationship_____
Name_____	Relationship_____
Name_____	Relationship_____

(use the back of paper if necessary)

21. Participant's Housing Type_____ Island_____

Other housing to be pursued in the future (e.g. on waitlist for public housing):

22. One-time Transition Services to be Used:

23. Use of Telemedicine? _____Yes _____No

Date of Equipment Installation_____

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Date of Telemedicine Training_____

24. Issues to Follow-up on:

25. Date that Person Transitioned from the Facility_____

26. Name of RACC Caregiver (if applicable)_____

Did the caregiver receive training from the Training Institute?

____ Yes ____ No ____ D/K

27. Waiver Program Enrolled In _____