Reset Form

STATE OF ALABAMA GATEWAY TO COMMUNITY LIVING
COMMUNITY TRANSITION PLAN

☐ Initial ☐ Final **Projected Date of Transition:** _____ **Actual Date of Transition:** _____ **Initial QoL Completion Date:** _____

Medicaid ID #: _____ **Primary Medicaid Service Provider:** _____
First Name: _____ **Middle Initial:** ___ **Last Name:** _____
Address: _____ **City:** _____ **State:** ___ **Zip:** _____
Date: _____ **Facility Name:** _____

I. TRANSITION TASK PLANNING:

Task Number	Written Task
01 Adequate Housing	**i. Specify Housing Type Desired:** **Plan for Completion:** **Date Due:** _____ ☐ Home Provided by Individual/Family ☐ Home Search to be completed by Individual/Family ☐ Housing Coordination Services Needed **ii. Specify Accessibility Modifications Needed:** ☐ 01-Indoor Structural Adaptations: ☐ 02-Outdoor Structural Adaptations: ☐ 03-Security Adaptations: ☐ 04-Smart Home Adaptations: ☐ 05-Other (Specify) ☐ 06-None Required **Plan for Completion:** **Date Due:** _____ ☐ Waiver POC ☐ Other (Non-Waiver) Resources ☐ Check if Housing Accessibility Services Needed:
02 Essential Transportation	**i. Specify Transportation Needs:** ☐ 01-Transportation for health care ☐ 02-Transportation for employment ☐ 03-Other transportation **Plan for Completion** ☐ 01-Will provide/arrange for own transportation ☐ 02-Can use public transportation ☐ 03-Can use public accessible transportation ☐ 04-Other:

I. TRANSITION TASK PLANNING:

Task Number	Written Task
03 Direct Support	**i. Specify In-Home Support Required:** 01-Personal Assistance/Personal Care ☐ 01.1 - Less Than 4 hours ☐ 01.2 - Four-12 hours in home support daily ☐ 01.3 - Twelve-24 hours in home support daily **Plan for Completion:** **Date Due:** _____ **Indicate the planned number of hours to be provided through the waiver, informal caregivers or other sources:** ☐ Waiver POC: ☐ In-home support provided by family/informal caregiver: ☐ Other 02-Homemaker ☐ 02.1 Less than 4 hours ☐ 02.2 4-12 hours in home support daily: ☐ 02.3 12-24 hours in home support daily: **Plan for Completion:** **Date Due:** _____ **Indicate the planned number of hours to be provided through the waiver, informal caregivers or other sources:** ☐ Waiver POC: ☐ In-home support provided by family/informal caregiver: ☐ Other 03-Companion/Supervision ☐ 03.1-Less than 4 hours ☐ 03.2- Four-12 hours in home support daily: ☐ 03.3-Twelve-24 hours in home support daily: **Plan for Completion:** **Date Due:** _____ **Indicate the planned number of hours to be provided through the waiver, informal caregivers or other sources:** ☐ Waiver POC: ☐ In-home support provided by family/informal caregiver: ☐ Other ☐ 04-Other **Plan for Completion:** **Date Due:** _____ **Indicate the planned number of hours to be provided through the waiver, informal caregivers or other sources:** ☐ Waiver POC: ☐ In-home support provided by family/informal caregiver: ☐ Other ☐ 05-No In-Home Support Required **ii. Specify Level of Skilled Care Required** ☐ 01-Less than 6 hours skilled care weekly: ☐ 02-More than 6 hours skilled care weekly: ☐ 03-No skilled care required **Plan for Completion:** **Date Due:** _____ **Indicate the planned number of hours to be provided through the waiver, informal caregivers or other sources:** ☐ Waiver POC: ☐ Other:

I. TRANSITION TASK PLANNING:

Task Number	Written Task
04 DME	i. **Specify DME Required:** ☐ 01-Electric/Customized wheelchair **Plan for Completion:** ☐ Currently Owns ☐ Waiver POC ☐ State Plan Medicaid ☐ Other: ☐ 02-Hospital bed(s) **Plan for Completion:** ☐ Currently Owns ☐ Waiver POC ☐ State Plan Medicaid ☐ Other: ☐ 03-Hoyer lift(s) **Plan for Completion:** ☐ Currently Owns ☐ Waiver POC ☐ State Plan Medicaid ☐ Other: ☐ 04-Trapeze/grab bars **Plan for Completion:** ☐ Currently Owns ☐ Waiver POC ☐ State Plan Medicaid ☐ Other: ☐ 05-Bedside commode **Plan for Completion:** ☐ Currently Owns ☐ Waiver POC ☐ State Plan Medicaid ☐ Other: ☐ 06-Walker **Plan for Completion:** ☐ Currently Owns ☐ Waiver POC ☐ State Plan Medicaid ☐ Other: ☐ 07-Shower chair/trolley **Plan for Completion:** ☐ Currently Owns ☐ Waiver POC ☐ State Plan Medicaid ☐ Other: ☐ 08-Other: **Plan for Completion:** ☐ Currently Owns ☐ Waiver POC ☐ State Plan Medicaid ☐ Other:
05 Health Care Providers	i. **Specify Health Care Provider Required:** ☐ *01-Primary Care Provider* Name: Address: Phone: ☐ *02-Medical Specialist:* ☐ *2.1-Neurologist* Name: Address: Phone: ☐ *02.2-Cardiologist* Name: Address: Phone: ☐ *02.3-Endocronologist* Name: Address: Phone: ☐ *02.4-Orthopedist* Name: Address: Phone: ☐ *02.5-Psychiatrist* Name: Address: Phone: ☐ *02.6-Pulmonologist* Name: Address: Phone: ☐ *02.7-Podiatrist* Name: Address: Phone: ☐ 02.8-Opthalmologist/Optometrist Name: Address: Phone: ☐ 03-Dentist Name: Address: Phone: ☐ 04-Pharmacy Name: Address: Phone:

I. TRANSITION TASK PLANNING:

Task Number	Written Task
05 Health Care Providers	☐ 05-Rehabilitative Providers ☐ 05.1-Physical Therapist Name: Address: Phone: ☐ 05.2-Occupational Therapist Name: Address: Phone: ☐ 05.3-Speech Therapist Name: Address: Phone: ☐ 05.4-Respiratory Therapist Name: Address: Phone: ☐ 06-Other: Name: Address: Phone:
06 Employment/ Day Support Program	**i. Specify Employment/Day Support Desired:** **Plan for Completion:** **Date Due:** ☐ ADRS employment services ☐ Waiver POC employment services ☐ Adult day health services ☐ Other:
07 Other	**i. Specify Other Needs:** ☐ 01-Safety/Security: **Plan for Completion:** **Date Due:** **Indicate the services/supports to be provided through the waiver, informal caregivers or other sources:** ☐ Waiver POC: ☐ Safety/security support provided by family/informal caregiver: ☐ Other ☐ 02-Other **Plan for Completion:** **Date Due:** **Indicate the services/supports to be provided through the waiver, informal caregivers or other sources:** ☐ Waiver POC: ☐ Safety/security support provided by family/informal caregiver: ☐ Other

II. BACK-UP PLANNING FOR ESSENTIAL SERVICES

An individualized back up plan is required for all essential services. Essential services are those necessary to eliminate undue risk to health and safety and must include the following if identified in the individual's transition tasks above: 02) Essential Transportation; 03) Direct Support; 04) DME. Other services in the transition plan should be designated as essential based on individual need. Back-up plans must be documented below and may include a combination of back-up service providers and informal supports who have agreed to provide back-up services. For each back-up support, provide the name and phone number.

Primary Back-up Plan: Provide the **name of the person or organization** that has agreed to ensure back-up availability if all other measures fail.	**Name:** _____ **Address:** _____ **Phone:** _____

Service	Essential	Back-Up Plan
01 Direct Support	√	01-Back-up Service Provider: Name: _____ Phone: _____ 02-Informal Support: Name: _____ Phone: _____
02 Personal emergencies	☐	01-Back-up Service Provider: Name: _____ Phone: _____ 02-Informal Support: Name: _____ Phone: _____
03 Access to medical care	☐	01-Back-up Service Provider: Name: _____ Phone: _____ 02-Informal Support: Name: _____ Phone: _____
04 Transportation	☐	01-Back-up Service Provider: Name: _____ Phone: _____ 02-Informal Support: Name: _____ Phone: _____
05 Community-wide emergencies	☐	Name: _____ Phone: _____ 02-Informal Support: Name: _____ Phone: _____
06 Repair/Replacement of DME and/or necessary equipment	☐	01-Back-up Service Provider: Name: _____ Phone: _____ 02-Informal Support: Name: _____ Phone: _____
07 Other (Specify)	☐	01-Back-up Service Provider: Name: _____ Phone: _____ 02-Informal Support: Name: _____ Phone: _____

III. TRANSITIONAL AND DEMONSTRATION SERVICES NEEDED

Service	Projected Needs (Scope/Amount)	Date Authorized
01-Housing Coordination	Number of hours:	
02-Housing Accessibility	☐ 01-Assistive Technology Evaluation ☐ 02 -Assistive Technology ☐ 02.1-Power and manual wheelchairs, scooters, canes, walkers, and standing devices: ☐ 02.2-Augmentative communication devices: ☐ 02.3-Other Housing Accessibility Needs: ☐ 03-Environmental Adaptations ☐ 03.1-Accessibility adaptations to the home: ☐ 03.2-Remote supervision technology/personal emergency response systems: ☐ 03.3-Other:	
03-Transitional Assistance	☐ 01-Rental/SecurityDeposit: ☐ 02-Utility Deposit: ☐ 02.1-Telephone: ☐ 02.2-Electricity: ☐ 02.3-Gas: ☐ 02.4-Water: ☐ 02.5-Other: ☐ 03-Household Items: ☐ 03.1-Furniture: ☐ 03.2-Window coverings: ☐ 03.3-Food preparation items: ☐ 03.4-Bed/bath linens: ☐ 03.5-Other (specify): 04-Household Services: ☐ 04.1-Pest eradication: ☐ 04.2-One-time cleaning: ☐ 04.3-Other: ☐ 05-Other: ☐ 06-None Required	

Press here to return to Section I - Transition Task Planning: Section I

IV. ITP Participants: Print Name/Title or Relationship	Signature