

PARTICIPANT BACKGROUND INFORMATION AND ADVOCACY

Last Name	First Name	Social Security No.	Medicaid No.	Date of Birth	Transition Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

1. WHAT WERE THE REASONS FOR ENTERING THIS FACILITY?

- Treatment of medical condition, illness or injury
- Health or personal care problems while in the community
- Unable to return home from hospital or rehabilitation facility
- Difficulty in maintaining community residence
- Home modification or accessibility issues
- Community and/or informal supports did not meet my needs
- Financial problems
- Family conflict or loss of family support
- Adult Protective Services recommendation
- Other

Question #1 Notes

2. WHO MADE THE DECISION FOR YOU TO MOVE TO A FACILITY?

- Self
- Doctor
- Family
- Court Ordered
- Legal Representative
- Other

Question #2 Notes

3. WERE YOU INFORMED OF ANY OTHER OPTIONS?

- Yes
- No

Question #3 Notes

4. WHAT BARRIERS WOULD YOU ANTICIPATE UPON LEAVING THE FACILITY?

- Family Objections
- Financial limitations
- Housing
- Obtaining food
- Transportation
- Obtaining medications
- Language or Communication
- None or Other

Question #4 Notes

5. HAVE YOU BEEN NOTIFIED THAT YOU WILL HAVE TO MOVE FROM THE FACILITY?

- Yes
- No

Question #5 Notes

6. WHAT SUPPORTS COULD YOU RECEIVE FROM FAMILY AND/OR FRIENDS?

- None
- Health management
- Financial assistance or management
- Moving assistance
- Furniture and/or household items
- Guardianship
- Personal care assistance or management
- SSA Payee
- Shopping and/or errands
- Housing
- Medication administration and/or management
- Transportation
- Other

Question #6 Notes

SECTION A. HOUSING

7. WHAT WERE YOUR PREVIOUS LIVING ARRANGEMENTS?

- Lived with family or friend in their home
- Lived in own home - alone
- Lived in own home - with family
- Lived in rented apartment or house
- Lived with caregiver or roommate
- Homeless
- Other

Question #7 Notes

8. WHAT TYPE OF LIVING ARRANGEMENT DO YOU DESIRE NOW?

- Return to previous residence
- Rent apartment
- Rent house
- Live with family and/or friends
- Live with caregiver or roommate
- Other

Question #8 Notes

9. WILL YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING?

- None
- Location of appropriate housing
- Filling out housing applications
- Finding a roommate and/or live in caregiver
- Paying for initial housing costs (deposits, utilities, etc.)
- Modifications to existing housing
- Other

Question #9 Notes

10. TELL ME ABOUT YOUR RENTAL HISTORY

- Rent always paid on time
- Late or unpaid rent
- Eviction
- Denied housing
- Bad credit rating
- Criminal history
- Other

Question #10 Notes

11. DO YOU HAVE FURNITURE OR OTHER PERSONAL BELONGINGS THAT CAN BE MOVED TO YOUR NEW RESIDENCE?

- Yes
- No

Question #11 Notes

12. WILL SOMEONE BE AVAILABLE TO MOVE FURNITURE AND/OR PERSONAL BELONGINGS?

- Yes
- No

Question #12 Notes

SECTION B. PHYSICAL AND MENTAL HEALTH

13. WHAT IS YOUR PRIMARY DISABILITY?

- Physical disability
- Mental Illness
- Substance Abuse
- Intellectual and/or Developmental Disability
- Traumatic Brain Injury
- Other

Question #13 Notes

14. DO YOU HAVE ANY CURRENT AND PRIMARY HEALTH CARE PROBLEMS?

- Yes
- No
- Attached

Question #14 Notes (Attach diagnosis list from facility chart)

15. DO YOU HAVE ANY ALLERGIES?

- Yes
- No

Question #15 Notes

16. DO YOU TAKE ANY PRESCRIPTION AND/OR NON-PRESCRIPTION MEDICATIONS?

- Yes
- No
- Attached

Question #16 Notes (Attach current MAR sheet)

17. DO YOU KNOW WHAT MEDICATIONS YOU TAKE?

- Yes
- No

Question #17 Notes

18. WHAT THERAPIES ARE YOU CURRENTLY RECEIVING?

- Speech or Language Therapy
- Occupational Therapy
- Physical Therapy
- Respiratory Therapy
- Chemotherapy or Radiation Therapy
- Dialysis
- Intravenous Drug Therapy
- Other
- None

Question #18 Notes

19. WHICH DOCTOR(S) OR SPECIALISTS DO YOU SEE?

- Primary Care Physician - Nursing Facility
- Primary Care Physician - Private
- Specialists
- Other

Question #19 Notes

20. DO YOU HAVE UNTREATED DENTAL NEEDS?

Yes Question #20 Notes

No

21. DO YOU HAVE UNTREATED VISION NEEDS?

Yes Question #21 Notes

No

22. HAVE YOU EVER BEEN DIAGNOSED DEMENTIA CARE OR RELATED NEEDS?

Yes No

Question #22 Notes

23. HAVE YOU EVER BEEN DIAGNOSED WITH A MENTAL HEALTH CONDITION?

Yes No

Question #23 Notes

24. HAVE YOU EVER BEEN TREATED FOR A MENTAL HEALTH CONDITION?

No Question #24 Notes

- Inpatient treatment facility
- Outpatient treatment facility
- Involuntary or voluntary commitment
- Other

25. ARE YOU CURRENTLY TAKING MEDICATION FOR A MENTAL HEALTH CONDITION?

Yes No MAR SHEET ATTACHED

Question #25 Notes

26. ARE YOU CURRENTLY RECEIVING TREATMENT OR COUNSELING FOR A MENTAL HEALTH CONDITION?

Yes No

Question #26 Notes

27. HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE?

Yes No

Question #27 Notes

28. HAVE YOU EVER HAD A LOSS OF A JOB, HOME OR FAMILY DUE TO SUBSTANCE ABUSE?

- Yes
- No

Question #28 Notes

29. DO YOU HAVE A HISTORY OF ASSOCIATING WITH PEOPLE (INCLUDING FAMILY) WHO ABUSE OR USE DRUGS OR ALCOHOL?

- Yes
- No

Question #29 Notes

30. HAVE YOU EVER BEEN TREATED FOR A SUBSTANCE ABUSE PROBLEM?

- No
- Inpatient treatment facility
- Outpatient treatment facility
- Involuntary or voluntary commitment
- Other

Question #30 Notes

31. ARE YOU CURRENTLY RECEIVING TREATMENT OR COUNSELING FOR A SUBSTANCE ABUSE PROBLEM?

- Yes
- No

Question #31 Notes

SECTION C. DAILY LIVING - PERSONAL ASSISTANCE - ASSISTIVE TECHNOLOGY

32. HOW DID YOU MANAGE YOUR DAILY LIVING ACTIVITIES PRIOR TO ENTERING THE FACILITY?

- I managed my own daily living needs.
- I managed my own daily living needs with attendant services.
- Daily living assistance was provided by family and/or friends.
- Daily living assistance was provided by a community provider.
- Other

Question #32 Notes

33. HAVE YOU EVER RECEIVED ANY OF THE FOLLOWING COMMUNITY SERVICES?

- None
- Aged and Disabled Waiver
- Traumatic Brain Injury Waiver
- I/DD Waiver
- Medicaid Personal Care Services
- Medicaid Home Health Services
- Medicare Home Health Services
- Behavioral Health Rehabilitation Services
- Behavioral Health Clinic Services
- Other

Question #33 Notes

34. HAVE YOU EVER BEEN REFUSED SERVICES BY A COMMUNITY PROVIDER?

- Yes
- No

Question #34 Notes

35. HAS ADULT PROTECTIVE SERVICES EVER BEEN INVOLVED?

- Yes Question #35 Notes
- No

36. DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING DAILY LIVING TASKS?

- Walking, using a wheelchair, cane or other mobility device
- Transferring from bed or a chair
- Eating
- Taking medications
- Toileting
- Bathing and/or personal hygiene
- Planning and/or preparing healthy meals
- Preparing grocery or shopping lists
- Shopping or errands
- Other

Question #36 Notes

37. DO YOU NEED ASSISTANCE OR SUPERVISION TO SAFELY COMPLETE CERTAIN ACTIVITIES?

- Yes Question #37 Notes
- No

38. DO YOU NEED ASSISTANCE OR SUPERVISION AT ALL TIMES TO BE SAFE?

- Yes Question #38 Notes
- No

39. WHEN YOU LEAVE THE FACILITY, WILL YOU HAVE A NEED FOR ANY OF THE FOLLOWING?

- Hearing aids
- Modified phone
- Communication device
- Amplification device
- Glasses
- Modified utensils
- Devices for operating lamps, radios, or other appliances
- Modified door knobs
- Wheelchair, cane, walker, or other device or prosthesis
- Shower bench or chair
- Transfer equipment and/or Hoyer lift
- Hospital bed or therapeutic mattress
- Incontinence supplies
- Other

Question #39 Notes

40. WILL YOU NEED ASSISTANCE WITH OBTAINING ANY OF THE ITEMS CHECKED IN QUESTION #39?

Yes Question #40 Notes

No

41. WILL YOU NEED ASSISTANCE IN LEARNING HOW TO USE ANY OF THE ITEMS CHECKED IN QUESTION #39?

Yes Question #41 Notes

No

42. WILL YOU NEED ASSISTANCE WITH TRAINING FOR COMPUTERS OR OTHER ASSISTIVE TECHNOLOGY DEVICES?

Yes Question #42 Notes

No

SECTION D. TRANSPORTATION

43. WHAT TYPE OF TRANSPORTATION WILL YOU LIKELY HAVE AVAILABLE WHEN YOU GO HOME?

- Own vehicle - drive self
- Own vehicle - others to drive
- Family and/or friends provide transportation
- Community service provider
- Other community or civic organization
- Public transportation
- Para-transit system
- Other

Question #43 Notes

44. IF PUBLIC TRANSPORTATION OR PARA-TRANSIT SYSTEM IS AVAILABLE, DO YOU NEED ASSISTANCE COMPLETING THE APPLICATION PROCESS?

Yes Question #44 Notes

No

45. IF PUBLIC TRANSPORTATION OR PARA-TRANSIT SYSTEM IS AVAILABLE, DO YOU NEED ASSISTANCE LEARNING HOW TO USE IT?

Yes Question #45 Notes

No

SECTION E. SOCIAL - FAITH - RECREATION

46. DO YOU HAVE FAMILY AND/OR FRIENDS IN THE AREA?

Yes Question #46 Notes

No

47. IF YOU HAVE FAMILY AND/OR FRIENDS NEARBY, HOW OFTEN DO YOU SEE THEM?

More than once a week Question #47 Notes

- Once a week
- Once a month
- Infrequently
- Never
- Other

48. WOULD YOU LIKE TO HAVE MORE CONTACT WITH FAMILY AND/OR FRIENDS?

- Yes
- No

Question #48 Notes

49. DO YOU HAVE A LOCAL CHURCH AFFILIATION?

- Yes
- No - Don't want one
- No - Would like one

Question #49 Notes

50. WHEN YOU LEAVE THE FACILITY, WILL YOU NEED ASSISTANCE FINDING OR ACCESSING ANY OF THE FOLLOWING?

- Place of worship
- Senior Center
- Recreation center
- Support group
- Other

Question #50 Notes

51. DO YOU HAVE ANY HOBBIES OR INTERESTS YOU WOULD LIKE TO CONTINUE OR RESUME AFTER MOVING HOME?

- Yes
- No

Question #51 Notes

SECTION F. EMPLOYMENT OR VOLUNTEERISM

52. DO YOU HAVE ANY EMPLOYMENT OR VOLUNTEERISM HISTORY?

- Yes
- No

Question #52 Notes

53. WHEN YOU LEAVE THE FACILITY, WOULD YOU BE INTERESTED IN WORKING AND/OR VOLUNTEERING?

- Yes
- No

Question #53 Notes

54. WILL YOU NEED ASSISTANCE ACCESSING OPPORTUNITIES FOR EMPLOYMENT AND/OR VOLUNTEERING?

- Yes
- No

Question #54 Notes

55. WILL YOU NEED ASSISTANCE ACCESSING EDUCATIONAL OR TRAINING OPPORTUNITIES OR ACTIVITIES?

- Yes
- No

Question #55 Notes

SECTION G. FINANCIAL AND PERSONAL RESOURCE MANAGEMENT

56. DO YOU CURRENTLY POSSESS ANY OF THE FOLLOWING DOCUMENTS?

- Social Security Card
- Birth Certificate
- Drivers' license or state photo ID
- Marriage certificate
- Medicaid card
- Medicare card
- Medicare Part D card
- Other

Question #56 Notes

57. WILL YOU NEED ASSISTANCE TO OBTAIN ANY OF THE ABOVE DOCUMENTS?

- Yes
- No

Question #57 Notes

58. WILL YOU NEED ANY ASSISTANCE WITH READING OR COMPLETING ANY DOCUMENTS OR APPLICATIONS?

- Yes
- No

Question #58 Notes

59. WILL YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING IN ORDER TO TRANSITION TO THE COMMUNITY?

- Establish legal representative
- Change legal representative
- Create a living will or advance directive
- Establish a payee
- Establish a bank account
- Establish direct deposit
- Transfer Social Security benefits
- Apply for food stamps
- Change of address
- Other

Question #59 Notes

60. WHAT ARE YOUR MONTHLY INCOME SOURCES?

- Social Security Income
- Social Security Disability Income
- Retirement or pension
- Veteran's benefits
- Spousal benefits
- Supplemental Security Income (SSI)
- Other

Question #60 Notes

61. WILL YOU NEED FINANCIAL ASSISTANCE TO PAY FOR TRANSITION START-UP COSTS?

Yes Question #61 Notes

No

62. WILL YOU NEED ASSISTANCE WITH DEVELOPING A MONTHLY BUDGET AND/OR WITH MONEY MANAGEMENT?

Yes Question #62 Notes

No

63. DO YOU HAVE ANY UNPAID UTILITY BILLS OR OTHER ON-GOING DEBTS?

Gas Question #63 Notes

Electric

Water

Sewer

Phone

Trash

City Fees

Credit cards

Loan debts or defaults

Mortgage or rent

Other

None

64. WOULD YOU LIKE TO MEET WITH A COUNSELOR FROM A CREDIT COUNSELING CENTER?

Yes Question #64 Notes

No

65. DO YOU HAVE ANY UNRESOLVED LEGAL ISSUES?

Unpaid ticket(s) or fines Question #65 Notes

Bench warrants

Restraining orders

Felony convictions

Other

None

ADDITIONAL INFORMATION

66. DO YOU HAVE ANY QUESTIONS OR CONCERNS THAT HAVEN'T BEEN COVERED?

Yes Question #66 Notes

No

Last Name

First Name

Medicaid No.

67. ADDITIONAL INFORMATION NOT OTHERWISE COVERED BY THE ASSESSMENT?:

Question #67 Notes

Last Name

First Name

Medicaid No.

68. ADDITIONAL INFORMATION:

Additional Information From Previous Questions:

AUTHORIZING SIGNATURES (If Participant signs with a mark, two witnesses are required).

Signature of Participant or Legal Representative

Date of Signature

Signature of Witness

Date of Signature

Signature of Transition Navigator

Date of Signature

Signature of Witness

Date of Signature

Transition Navigator Name

Agency