SECTION A. INDIVIDUAL INFORMATION

1. Last Name | First Name | Middle Name | 2. Date of Birth | 3. Phone Number

4. Gender:

☐ M ☐ F

5. Social Security No.

6. Medicaid No.

7. 90 Consecutive Day Start Date

8. 90 Consecutive Day Start Date - Location

9. Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Other

10. Target Population

- ☐ Elderly
- ☐ Physical Disability
- ☐ Mental Illness

Question #1-10 Notes

SECTION B. HOUSING

11. Where were you living before you moved here?

Address

11a. Did you live with others? ☐ Yes ☐ No

11b. If so, whom?

11c. Did you receive assistance in your home? ☐ Yes ☐ No

11d. If so, what type of support?

- ☐ Regular help family and friends
- ☐ Aged & Disabled Waiver
- ☐ Traumatic Brain Injury Waiver
- ☐ Personal Care Program
- ☐ Hospice
- ☐ Home Health
- ☐ Self or private pay services
- ☐ Other assistance

If other, please specify

Last Name | First Name | Medicaid No.

12. Do you have housing to which you can return? ☐ Yes ☐ No

12a. If yes, Address

12b. Type of residence

- ☐ Home Owned by Participant - 01
- ☐ Home Owned by Family Member - 02
- ☐ Apartment Leased by Participant, NOT assisted living- 03
- ☐ Apartment Leased by Participant, assisted living - 04
- ☐ Group home of no more than 4 people - 05

12c. Would you live with others? ☐ Yes ☐ No

If yes, with whom?

12d. Would you need modifications and/or accommodations to the home to meet your current needs? ☐ Yes ☐ No

12e. If so, what?

13. If you don't have housing to return to, what type of housing would you like to find?

- ☐ Home Owned by Participant - 01
- ☐ Home Owned by Family Member - 02
- ☐ Apartment Leased by Participant, NOT assisted living- 03
- ☐ Apartment Leased by Participant, assisted living - 04
- ☐ Group home of no more than 4 people - 05
- ☐ Not applicable

13a. In what location?

13b. Living with whom?

Question #11-13 Notes

Last Name | First Name | Medicaid No.

SECTION C. INCOME AND INSURANCE

14. Do you have Medicaid? ☐ Yes ☐ No

15. Do you have Medicare? ☐ Yes ☐ No

16. Are you a Veteran? ☐ Yes ☐ No

16a. If so have you applied for Veteran's benefits? ☐ Yes ☐ No

17. Do you have long-term care insurance or some other type of health insurance? ☐ Yes ☐ No

17a. If yes, please explain

18. What type and amount of income do you receive on a regular basis (Please round to the nearest dollar amount)?

All jobs (including self-employment) before taxes and deductions $

Worker's Compensation $

Unemployment Benefits $

Social Security Retirement Survivors of Disability Income (RSDA) $

Dividends & Interest $

Supplemental Security Income (SSI) $

Child Support $

Alimony $

Pensions or Retirement $

Other $

19. Do you own a home with more than $536,000 in equity? ☐ Yes ☐ No

Last Name	First Name	Medicaid No.

SECTION D. FAMILY, FRIENDS AND REPRESENTATIVES

20. Do you have a legal representative? ☐ Yes ☐ No

20a. If yes (Check ALL that apply):

☐ Guardian ☐ Co-Guardian ☐ Conservator ☐ Health Care Surrogate ☐ POA ☐ MPOA

20b. Legal Representative Full Name	20c. Legal Rep Day Phone	20d. Legal Representative E-Mail	20e. Relationship

20f. If you have a legal representative, have you spoken to him /her about your interest in moving to the community? ☐ Yes ☐ No

If so, have they been supportive or unsupportive of a move? Please explain.

21. Have you spoken to family and friends about your interest in moving? ☐ Yes ☐ No

22. Do you have family or friends that you would like to be involved in planning for a move? ☐ Yes ☐ No

22a. If yes, who?

Name	Relationship	Phone #	Do they live locally?

Name	Relationship	Phone #	Do they live locally?

Questions #20-22 Notes

Last Name | First Name | Medicaid No.

SECTION E. FACILITY INFORMATION

23. Facility Name | 23a. Facility Address | 23b. Facility City

23c. Facility County | 23d. Facility Zip Code | 23e. Facility Phone | 23f. Facility Fax | 23g. Date of Facility Admission

24. Facility Contact Person and Title | 24a. Facility Contact Person E-mail Address

25. Type of Qualified Institution:
- ☐ Nursing Facility - 01
- ☐ IMD - 03
- ☐ Other- 04

SECTION F. INTAKE INFORMATION

26. Date of Intake | 27. Name of Transition Navigator Completing Intake | 28. Agency Completing Intake

29. Referral Source:
☐ ADRC - Section Q ☐ ADRC - Non-Section Q ☐ Self ☐ Family or Friend ☐ LTC Ombudsman
☐ Legal Aid Advocate ☐ Care Coordinator ☐ Community Provider ☐ Olmstead ☐ CIL ☐ Facility
☐ Other (please describe)

Describe "Other" Referral Source:

30. Date referral received from ADRC

SECTION G. ELIGIBILITY CHECKLIST (THIS SECTION IS TO BE COMPLETED BY THE TMH DIRECTOR OR DESIGNEE ONLY!)

1. Does the individual reside in a qualified institution?	☐ Yes	☐ No
2. Has the individual resided in a qualified institution for at least 90 days?	☐ Yes	☐ No
3. Is the individual part of a target population?	☐ Yes	☐ No
4. Is Medicaid currently reimbursing the facility for LTC services?	☐ Yes	☐ No
5. Is the individual currently a Medicaid member?	☐ Yes	☐ No
6. Does the individual wish to transition to a qualified residence?	☐ Yes	☐ No
7. Is the individual eligible for the TMH, West Virginia Program?	☐ Yes	☐ No

31. Additional Comments

SECTION H. AUTHORIZING SIGNATURES

Transition Navigator Name | Transition Navigator Signature | Agency | Date of Signature

Name of TMH Director or Designee | Signature of TMH Director or Designee | Agency | Date of Signature