Take Me Home, West Virginia
Transition Planning Tool - Version 5.2

Participant Last Name	Participant First Name	Participant Medicaid No.

SECTION A. HOUSING

Appropriate and Accessible Housing

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION A. HOUSING

Home Accessibility Needs Assessment

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION A. HOUSING

Home Modifications

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION A. HOUSING

Move From Nursing Facility To Home

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION B. PHYSICAL AND MENTAL HEALTH

Medication Management

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION B. PHYSICAL AND MENTAL HEALTH

Health Care Needs (i.e., vision, dental, etc.)

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION B. PHYSICAL AND MENTAL HEALTH

Primary and Specialty Physician Care

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION B. PHYSICAL AND MENTAL HEALTH

Needed Therapies (i.e., Physical Occupational, and Speech)

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION B. PHYSICAL AND MENTAL HEALTH

Identified Mental Health Conditions and Other Plan Components

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION C. DAILY LIVING- PERSONAL ASSISTANCE- ASSESTIVE TECHNOLOGY

In-home Services to Provide Assistance with Activities of Daily Living

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION C. DAILY LIVING- PERSONAL ASSISTANCE- ASSESTIVE TECHNOLOGY

Durable Medical Equipment (DME)

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION C. DAILY LIVING- PERSONAL ASSISTANCE- ASSESTIVE TECHNOLOGY

Personal Emergency Response System and Other Plan Components

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

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SECTION D. TRANSPORTATION

Essential Errands (i.e. shopping, medical appointments, etc.)

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

Community Activities (i.e. church, social outings, hobbies, etc.) and Other Plan Components

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

Last Name	First Name	Medicaid No.

SECTION E. SOCIAL/FAITH/RECREATION

Hobbies and Interests (Identification, strategies, etc.)

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

Social Network (Identification, strategies, etc.) and Other Plan Components

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

Last Name | First Name | Medicaid No.

SECTION F. EMPLOYMENT AND VOLUNTEERISM

Employment

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

Volunteerism and Other Plan Components

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

Last Name | First Name | Medicaid No.

SECTION G. FINANCIAL AND RESOURCE MANAGEMENT

Monthly Budget (including debt management)

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

Personal Records Management and Other Plan Components

What needs to be done to address identified need?	Who is responsible?	By when?	Will TMH Funds be requested?	Date Completed

Last Name | First Name | Medicaid No.

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

Signature of Participant or Legal Representative | Date

Signature of Witness (1) | Date

Signature of Witness (2) | Date

Signature of Transition Navigator | Date

Name of Transition Navigator | Agency