

**OFFICE OF LONG-TERM LIVING**  
**Bureau of Participant Operations**  
**COMMUNITY LIVING PLAN**

1. Nursing Home Transition Coordination Agency (NHTCA): \_\_\_\_\_

2. Name and contact information of Nursing Home Transition Coordinator (NHTC): \_\_\_\_\_

\_\_\_\_\_

3. Selected Service Coordination Entity (SCE): \_\_\_\_\_

4. Participant's community address and residential county:

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

County: \_\_\_\_\_

5. Other individuals who will be residing with the participant: \_\_\_\_\_

\_\_\_\_\_

6. Income Source(s): \_\_\_\_\_

\_\_\_\_\_

7. Transportation:

- MATP
- Public transportation
- Private transportation provided by informal support
- Other \_\_\_\_\_

8. List informal supports and how they plan to assist the participant: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**9. Program participant has applied for:**

- Waiver
- ACT 150
- Options
- Family Caregiver Support Program (FCSP)
- Other \_\_\_\_\_

**10. Formal Services needed:**

- Personal Emergency Response System (PERS)
- Personal Care (identify frequency of care required): \_\_\_\_\_
- Home Delivered Meals (HDM)
- Personal Attendant Services (PAS) (identify frequency of service required): \_\_\_\_\_
- Transportation
- Home Adaptation
- Specialized medical equipment and supplies (SME) \_\_\_\_\_
- Adult Day Services (identify frequency of service required): \_\_\_\_\_
- Supplies (type) \_\_\_\_\_
- Other \_\_\_\_\_

**11. Services Provided through NHT:**

- Community Transition Services (CTS). (Items need to be added to the Individual Service Plan (ISP) by the SCE):
  - \$ \_\_\_\_\_ W7332 (Equipment, furnishings, initial supplies)
  - \$ \_\_\_\_\_ W7333 (NHT Moving expenses)
  - \$ \_\_\_\_\_ W7334 (Security deposit or one time required move in fees)
  - \$ \_\_\_\_\_ W7335 (Utility set up, deposit for utility such as telephone, electric, or heating)
  - \$ \_\_\_\_\_ W7336 (Personal environmental safeguards such as pest eradication or one time cleaning)
- Home Adaptations (description and cost). (Need to be added to the ISP by the SCE):  
\_\_\_\_\_
  - \$ \_\_\_\_\_ Home adaptation cost (Reimbursable costs expended by the NHTCA for necessary adaptations required prior to transition)

Special Nursing Home Transition Funding (SNHTF):

\$ \_\_\_\_\_ Groceries

\$ \_\_\_\_\_ Other: (description of items) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**12. Services ordered by Nursing Facility:**

Medicare

Medicaid

Medications

Supplies

Therapy

Specialized training provided to informal supports such as feeding tube care, ventilator care, diabetic care etc.: \_\_\_\_\_

**13. Community physician(s):** \_\_\_\_\_

**14. Time and Date of first community appointment with Physician:** \_\_\_\_\_

**15. List any specialists such as therapists, dialysis etc.:** \_\_\_\_\_

\_\_\_\_\_

**16. Mental Health services and provider:** \_\_\_\_\_

**17. Substance abuse services and provider:** \_\_\_\_\_

**18. Other agencies or organizations that are involved:**

Child services

Probation or parole

Church groups

Civic organizations

Protective services

Ombudsman

Other social services or programs \_\_\_\_\_

\_\_\_\_\_

**19.** Has social security been notified of discharge if individual has social security as income?

- Yes, date of notification: \_\_\_\_\_
- No

**20.** Has IEB call center been notified of discharge date?

- Yes, date of discharge: \_\_\_\_\_
- No

**21.** Has IEB been notified of MFP status?

- Yes, date of notification: \_\_\_\_\_
- No

**22.** Please describe any identified risks that may not have been mitigated. These should also be captured on the NHT Care Plan Worksheet.

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**23.** Additional discharge orders that were provided by the nursing facility. This may include the need to fill narcotic medications post transition and insulin etc.:

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**24.** Additional comments: \_\_\_\_\_

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