

## MFP Transition and Risk Mitigation Plan

**Client's Name:** \_\_\_\_\_ **Medicaid#:** \_\_\_\_\_  
**SSN#:** \_\_\_\_\_ **Current Date:** \_\_\_\_\_ **Proposed Transition Date:** \_\_\_\_\_  
**County of Current Residence:** \_\_\_\_\_ **County of Proposed Residence:** \_\_\_\_\_

**Housing:** \_\_\_\_\_

- ❖ **Housing Type:**  Home  Apt  Group Home (4 or less)  Assisted Living
- ❖ **Rental Assistance Source:**  Home Choice Vouchers (Sec 8)  202 Funds  USDA rural housing  
 Low Income Housing Tax Credits  Public Housing Low Income  Other \_\_\_\_\_
- ❖ **Rental Cost** \_\_\_\_\_ **Income Amount** \_\_\_\_\_
- ❖ **Waiver of Choice:**  Elders Choices  Alternatives for Persons with Physical Disabilities  
 Living Choices  Alternative Community Services

**Moving Logistics:** \_\_\_\_\_  
\_\_\_\_\_ **Amount** \_\_\_\_\_

**Transition Services Needed :( attach separate page if additional space if needed)** \_\_\_\_\_  
\_\_\_\_\_ **Amount** \_\_\_\_\_

**Goods and Services Needed :( attach separated page if additional space if needed)** \_\_\_\_\_  
\_\_\_\_\_ **Amount** \_\_\_\_\_

**Other concerns:** \_\_\_\_\_  
\_\_\_\_\_

Risk Identified	What is the teams (individual, guardian, support coordinator, etc.) evaluation of the risk?	<b>(Primary Plan)</b> Briefly describe primary plan and Person(s) Responsible for Primary Plan?	<b>(Back-up Plan)</b> Briefly describe back up plan and Person(s) Responsible for Back-up Plan?
<b>Nutrition</b> (To ensure proper meals and diet)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____
<b>Risk of Institutionalization</b>	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____
<b>Health</b> (To provided the necessary health care)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____
<b>Transportation</b> (To ensure appointment and errands are being met)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____

<b>Fall Risk</b> (Physical & Mobility)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____
<b>Social Needs</b> (so that isolation does not lead to depression)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____
<b>Direct Service Worker</b> (Absence will increase likelihood of institutionalization)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____
<b>Behavior Mental Health</b> (Control Depression and other Mental Illness)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____
<b>Repairs &amp; Replacement of Medical and Other Equipment</b> (Mobility wheelchair isolation and other necessary equipment)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____

<b>Fragility of the Informal Caregiver System</b>	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____
<b>Other (Specify)</b>	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	Plan: _____ _____ Responsibility: _____ _____	Plan: _____ _____ Responsibility: _____ _____

- I have participated in completing my transition- risk mitigation plan.
- I understand and agree with terms of my transition-risk mitigation plan.

\_\_\_\_\_  
Client's Name/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Intense Transition Manager

\_\_\_\_\_  
Date