# 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:** ☐ **ARChoices** ☐ **Living Choices (Assisted Living)** ☐ **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? | **(Primary Plan)** Briefly describe primary plan and Person(s) Responsible for Primary Plan? | **(Back-up Plan)** Briefly describe back up plan and Person(s) Responsible for Back-up Plan? |
|---|---|---|---|
| **Nutrition** (To ensure proper meals and diet) | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______<br>Responsibility: ______ | Plan: ______<br>Responsibility: ______ |
| **Risk of Institutionalization** | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______<br>Responsibility: ______ | Plan: ______<br>Responsibility: ______ |
| **Health** (To provided the necessary health care) | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______<br>Responsibility: ______ | Plan: ______<br>Responsibility: ______ |
| **Transportation** (To ensure appointment and errands are being met) | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______<br>Responsibility: ______ | Plan: ______<br>Responsibility: ______ |

| | | | |
|---|---|---|---|
| **Fall Risk** (Physical & Mobility) | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______________________<br>______________________<br>Responsibility: ______________<br>______________________ | Plan: ______________________<br>______________________<br>Responsibility: ______________<br>______________________ |
| **Social Needs** (so that isolation does not lead to depression) | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______________________<br>______________________<br>Responsibility: ______________<br>______________________ | Plan: ______________________<br>______________________<br>Responsibility:______ ______<br>______________________ |
| **Direct Service Worker** (Absence will increase likelihood of institutionalization) | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______________________<br>______________________<br>Responsibility: ______ ______<br>______________________ | Plan: ______________________<br>______________________<br>Responsibility:______ ______<br>______________________ |
| **Behavior Mental Health** (Control Depression and other Mental Illness) | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______________________<br>______________________<br>Responsibility: ______________<br>______________________ | Plan: ______________________<br>______________________<br>Responsibility: ________ _____<br>______________________ |
| **Repairs & Replacement of Medical and Other Equipment** (Mobility wheelchair isolation and other necessary equipment) | ☐ High<br>☐ Medium<br>☐ Low | Plan: ______________________<br>______________________<br>Responsibility: ______________<br>______________________ | Plan: ______________________<br>______________________<br>Responsibility: ______ ______<br>______________________ |

| **Fragility of the Informal Caregiver System** | ☐ High<br>☐ Medium<br>☐ Low | Plan: ____________________<br>____________________<br>Responsibility: ____________________<br>____________________ | Plan: ____________________<br>____________________<br>Responsibility: ____________________<br>____________________ |
|---|---|---|---|
| **Other (Specify)** | ☐ High<br>☐ Medium<br>☐ Low | Plan: ____________________<br>____________________<br>Responsibility: ____________________<br>____________________ | Plan: ____________________<br>____________________<br>Responsibility:____________________<br>____________________ |

- 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 Signature Date