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| **ENROLLEE INFORMATION** | | | | | | | | |
| Enrollee’s Name (Last, First): | |  | | | | | | |
| Enrollee’s Medicaid ID Number: | |  | | | | Date of Birth: | |  |
| Managed Care Plan: | |  | | | | Enrollee's Age: | |  |
| Care Coordinator: (Last, First) | |  | | | | | | |
| Care Coordinator’s Phone Number: | |  | | | | | | |
| Name of Current Nursing Facility: | |  | | | | Admission Date: | |  |
| Current Nursing Facility’s Address: | |  | | | | | | |
| Current Nursing Facility’s Phone Number: | |  | | | | | | |
| Date of Nursing Facility Admission: | |  | | | | | | |
| Parent/Guardian’s Name(s) (Last, First): | |  | | | | | | |
| Relationship to Enrollee: | |  | | | | | | |
| Address: | |  | | | | | | |
| Phone Number(s): | |  | | | | | | |
| Email Address(es): | |  | | | | | | |
| Preferred Language: | |  | | | | | | |
| Preferred Method of Contact: | |  | | | | | | |
| Date of Last Freedom of Choice Certification: | |  | | | | | | |
| ~~Parent/Guardian’s Choice of Setting:~~ | | ~~Home or other Community Setting~~ ~~Nursing Facility~~ | | | | | | |
| ~~Date & Place of Proposed Discharge (including address, if known):~~  ~~N/A~~ | |  | | | | | | |
| **ENROLLEE HEALTH HISTORY** | | | | | | | | |
| Health Conditions/Diagnoses: |  | | | | | | | |
| Functional Status: |  | | | | | | | |
| Summary of Events that Led to Nursing Facility Admission: |  | | | | | | | |
| History of Service Utilization (e.g., ED, hospitalizations): |  | | | | | | | |
| Current Medications | Medication | | | Dose | | | Route | Frequency |
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| Current Services (Including therapy services) | Service/Frequency | | | | | | Provider Name & Telephone Number | |
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| Current Durable Medical Equipment (DME)/Supplies: | DME/Supplies | | | | | | DME Provider Name & Telephone Number | |
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| **MEETING DISCLOSURES AND PROCEDURAL INFORMATION** | | | | | | | | |
| To be provided to the parent(s)/guardian(s) before the meeting begins and in their preferred language:  (check all that were reviewed with the parent(s)/guardian(s))  A Federal court has ordered Florida to engage in a transition planning process for children who live in nursing homes. You do **NOT** have to move your child out of the nursing home. Your child may continue to live in their current nursing home. It is your choice.  A Federal Court has ordered the State to provide reliable Private Duty Nursing (PDN) to all children who transition to the Community from a Nursing Facility.  The transition planning process will provide you with information about the services that might be available to your child if you choose to bring your child home.  The transition planning process will result in a written Transition Plan. The Transition Plan will describe what would need to be done to transition your child home, any barriers that may prevent your child’s transition home or to the community, and ways to overcome those barriers.  You may invite your child’s primary care physician, a family advocate, or others to this meeting. (Date this was discussed with parent(s)/guardian(s): \_\_\_\_\_\_\_\_\_\_\_)  Consent to record obtained from all meeting participants and HIPAA reviewed/verified on recording device (e.g., Teams, Zoom) | | | | | | | | |
| **TRANSITION PLAN MEETING** | | | | | | | | |
| Date of Transition Plan: |  | | | | Original Update | | | |
| Location of Meeting: In Person Virtual Phone | | | | | | | | |
| Language Interpreter Offered:  Yes No N/A | | | Language Interpreter Used:  Yes No N/A | | | | | |
| **Participants Present (check all present and list names)** | | | | | | | | |
| Enrollee: |  | | | | | | | |
| Parent/Guardian Name (Last, First) and Relationship to Enrollee: |  | | | | | | | |
| Managed Care Plan Care Coordinator and/or other Plan Staff: |  | | | | | | | |
| Managed Care Plan Medical Staff: |  | | | | | | | |
| Nursing Facility Care Coordinator: |  | | | | | | | |
| Nursing Facility Staff – Other: |  | | | | | | | |
| Primary Care Physician: |  | | | | | | | |
| Specialty Physician: |  | | | | | | | |
| DCF Representative  N/A |  | | | | | | | |
| Other(s) (Relationship(s) to Recipient): |  | | | | | | | |
| Parent(s)/Guardian(s) unable to be reached after three attempts (Date follow up information mailed to parent(s)/guardian(s): \_\_\_\_\_\_\_\_\_\_\_)  Parent(s)/Guardian(s) declined to participate in transition plan meeting (Date follow up information mailed to parent(s)/guardian(s): \_\_\_\_\_\_\_\_\_\_\_)  Parent(s)/Guardian(s) agreed to participate but not present at time of meeting (Date follow up information mailed to parent(s)/guardian(s): \_\_\_\_\_\_\_\_\_\_\_)  ~~Parent(s)/Guardian(s) participated and wish to transition child~~  ~~Parent(s)/Guardian(s) participated, wish to transition child, and transition is in progress~~  ~~Parent(s)/Guardian(s) participated and declined to transition child at this time~~ | | | | | | | | |

**Service Definitions**

Service Definitions reviewed with parent(s)/guardian(s)

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| **Service** | **Description** |
| Care Coordination | * Support to assist you in obtaining all of the needed services for your child, including coordinating the transition from a nursing home to your home or the community setting of your choice |
| Private Duty Nursing (PDN) | * One-on-one, medically necessary nursing care from a skilled nurse * These services are available in your home and your child may be eligible to receive up to 24 hours a day of PDN per day * The court has ordered the State to provide reliable PDN to any child who transitions from a nursing home to the community |
| Medical Equipment and Supplies | * Items for every day, or extended use at home, including:   + Ventilation equipment and supplies   + Oxygen equipment and supplies   + Feeding equipment and supplies   + Mobility devices such as a wheelchair |
| Medical Transportation | * Non-emergency Medical Transportation for your child and a caregiver to medical appointments |
| Prescribed Pediatric Extended Care (PPEC) | * Centers for children through age 20 * Provides skilled nursing supervision, medical services, nursing services, personal care, psychosocial services, respiratory therapy services, and developmental therapies in a non-residential setting * Transportation is provided by the PPEC Center * Provides caregiver training * Available for up to 12 hours a day |
| Medical Foster Care | * A program for children through age 20 * Provides temporary placement for 24-hour care in a licensed foster home with specially trained foster parents * This program is time-limited unless the child is in state custody |
| Family-to-Family Home Visits | * An opportunity for you to visit other family homes where children are receiving PDN in the home * During the visit, you will observe PDN provided to their child and have an opportunity to ask questions * Visits can be in-person or virtual and your child’s care coordinator can accompany you |
| Family-to-Family Peer Support | * An opportunity to connect to a family that has received PDN for a child with complex medical needs * Interactions may be one-on-one, or with a group of families * Interactions may be in-person, virtual, or by phone |
| Expanded Benefits | * Benefits that are offered by your health plan, in addition to the standard benefit package. |
| Developmental Disabilities Individual Budgeting (iBudget) Waiver | * The iBudget Waiver is designed to promote and maintain the health of individuals with developmental disabilities and to provide medically necessary supports and services to prevent placement in a nursing home * Services are for eligible children 3 or older with a developmental disability * Services include:   + Home Modifications: Adaptations to home for accessibility, such as ramps and door-widening   + Vehicle Modifications: Adaptations to the vehicle for accessibility, including portable ramps   + Consumable Medical Supplies: such as diapers, wipes, and pads   + Residential Habilitation: Enables eligible children to live in licensed group homes up to 24 hours a day with nursing services and medical supervision * Your care coordinator can help you apply for this program through the Agency for Persons with Disabilities |
| Other Florida Medicaid Waiver Programs | * Long Term Care Waiver Program:   + The Long-term Care Waiver Program is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while receiving services at home and in the community. Individuals in the program may also be served in a nursing facility setting   + Service eligibility includes individuals 18 years of age or older and eligible for Medicaid by reason of disability and needs nursing facility level of care, or individuals 18 years of age or older with a diagnosis of cystic fibrosis and have a hospital level of care   + Services include over two dozen home and community-based services and nursing facility services through this program. This Waiver Program is offered as a managed care program   + Your Care Coordinator can help you apply for this waiver by completing a CARES (Comprehensive Assessment and Review for Long-Term Care Services) referral * Model Waiver Program:   + The Model Waiver Program is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while receiving services at home and in the community   + Services are for individuals 20 years of age or younger that:     - Are living at home, or are medically fragile and have resided in a skilled nursing facility for at least 60 consecutive days prior to entrance on the waiver     - Have a diagnosis of a degenerative spinocerebellar disorder which is generally identified in the 330-337 range of ICD9-CM diagnostic classifications, or is Medically Fragile as defined in F.A. C. 59G-1.010     - Meets the disability criteria for Social Security Disability     - Has a level of care determination of “at risk for hospital placement”, or must meet skilled nursing facility level of care determined by CMAT, and reside in a nursing facility for a minimum of 60 days     - Is able to live safely at home   + Services include:     - Assistive Technology and Service Evaluation     - Environmental Accessibility Adaptations     - Respite     - Transition Case Management   + This waiver is only available to Medicaid recipients that are fee-for-service * Familial Dysautonomia Waiver Program   + The Family Dysautonomia Waiver Program promotes and maintains the health of eligible recipients with Familial Dysautonomia and minimizes the effects of illness and disabilities through the provision of needed supports and services to delay or prevent hospital placement or institutionalization   + Services are for individuals who have been diagnosed with Familial Dysautonomia by a physician, are aged 3 through 64, and are at risk for hospitalization     - Adult Dental Services for recipients aged 21 years and older     - Behavioral Services     - Consumable Medical Supplies     - Durable Medical Equipment     - Non-Residential Support Services     - Respite Care     - Waiver Support Coordination * This waiver is only available to Medicaid recipients that are fee-for-service |

*\* ~~If your goals/barriers exceeds the amount of space given, please use the table provided in Appendix A for parent’s desires and barriers (pg. 19). If there are additional care plan-related goals and/or barriers identified by the care coordinator, and are not service related, add them to Appendix B (pg. 20).~~ If needed, rows can be added to care plan selections.*

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| **PARENT/GUARDIAN CHOICE OF SETTING** | | | | | | |
| I want my child to come home or move to a community setting  I want my child to stay in a nursing facility at this time, but I want to overcome identified barriers so my child can come home or transition to a community setting in the future  I want my child to stay in a nursing facility and oppose my child living at home or in a community setting | | | | | | |
| For now, we are required to conduct transition planning meetings every three months. If you could choose, how often would you want to have these transition planning meetings.  every 3 months  every 6 months  every 9 months  every 12 months | | | | | | |
| Date & Place of Proposed Discharge (including address, if known):  N/A | | | | | | |
| **PARENT(S)/GUARDIAN(S)/ENROLLEE’S GOALS AND BARRIERS** *~~(as identified by the parent(s)/guardian(s) and may also be incorporated into the care plan below)~~* | | | | | | |
| Goals for Child’s Placement: | | | | | | |
| Barriers to Child’s Transition: | | | | | | |
| **ACTION PLAN FOR TRANSITION** | | | | | | |
| **COMMUNITY-BASED SERVICES AND SUPPORTS** | | | | | | |
| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | **Action(s) Needed** | | **Responsible Person(s)** | **Due Date(s)** |
| **Care Coordination**  ☐ Education and individualized information about this services provided to parent(s)/guardian(s)  ☐ Other coordination/support to assist ~~with~~ transitioning |  |  |  | |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | **Action(s) Needed** | | **Responsible Person(s)** | **Due Date(s)** |
| **Private Duty Nursing (PDN)**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Home visits to other family homes offered where children are receiving PDN services, if applicable (see below)  Family-to-family peer support offered from a family that has received PDN for a child with complex medical needs, if applicable (see below)  Needed for Transition  Not Needed for Transition |  |  |  | |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Medical Equipment and Supplies**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Medical Transportation**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Prescribed Pediatric Extended Care (PPEC)**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Medical Foster Care**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Expanded Benefits**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Developmental Disabilities Individual Budgeting (iBudget) Waiver**  Individualized education provided to parent(s)/guardian(s) about services required under iBudget:  Home Modifications  Vehicle Modifications  Consumable Medical Supplies  Respite  Occupational Therapy  Speech Therapy  Physical Therapy  Respiratory Therapy  Behavior Analysis Services  Private Duty Nursing  Life Skills Development  Dietitian Services  Personal Emergency Response System  Skilled Nursing  Specialized Medical Equipment & Supplies  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Other Florida Medicaid Waiver Programs**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Additional Services and Supports**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Family-to-Family Home Visits**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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| **Service** | **Goal(s)/Need(s)** | **Barrier(s)** | | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
| **Family-to-Family Peer Support**  Education and individualized information about this service provided to parent(s)/guardian(s)  Outreach to connect parent(s)/ guardian(s) to services offered  Needed for Transition  Not Needed for Transition |  |  | |  |  |  |
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**Referral Information**

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| **Name of person receiving referral** | **Reason why referral was made** | **Date of referral** |
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| **ADDITIONAL STEPS NEEDED FOR TRANSITION**  (e.g., environmental, social, educational, etc.) | | | | | |
| **Step** | **Goal(s)/Need(s)** | **Barrier(s)** | **Action(s) Needed** | **Responsible Person(s)** | **Due Date(s)** |
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| **TRANSITION PLAN NOTES/SUMMARY** | | | | | |
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| Enrollee Signature: |  | | Date: |  | |
| Parent/Guardian Signature: |  | | Date: |  | |
| Managed Care Plan Care Coordinator Signature: |  | | Date: |  | |
| Nursing Facility Care Coordinator Signature: |  | | Date: |  | |

~~Appendix A. Additional Goal(s)/Needs(s) Not Mentioned Above~~

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| **~~Service~~** | **~~Goal(s)/Need(s)~~** | **~~Barrier(s)~~** | **~~Action(s) Needed~~** | **~~Responsible Person(s)~~** | **~~Due Date(s)~~** |
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~~Appendix B. Additional Care Plan Goals (Not Service Related)~~

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| **~~Goal(s)/Need(s)~~** | **~~Barrier(s)~~** | **~~Action(s) Needed~~** | **~~Responsible Person(s)~~** | **~~Due Date(s)~~** |
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