

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

ENROLLEE INFORMATION			
Enrollee's Name (Last, First):	Suarez, Jane		
Enrollee's Medicaid ID Number:	1234567890	Date of Birth:	01/14/2017
Managed Care Plan:	Health Plan's Name	Enrollee's Age:	7
Care Coordinator (Last, First):	Managed Care Plan Coordinator's Last & First Name		
Care Coordinator's Phone Number:	561-333-4444		
Name of Current Nursing Facility:	Nursing Facility's Name	Admission Date:	12/13/2017
Current Nursing Facility's Address:	123 Main Street, Plantation, FL		
Current Nursing Facility's Phone Number:	954-999-9999		
Date of Nursing Facility Admission:	12/13/2017		
Parent/Guardian's Name(s) (Last, First):	Suarez, Janet		
Relationship to Enrollee:	Mother		
Address:	1110 Seasonal Street, Miami Gardens, FL 33014		
Phone Number(s):	305-234-4321		
Email Address(es):	xxxxxx@emailaccount.com		
Preferred Language:	English		
Preferred Method of Contact:	Phone		
Date of Last Freedom of Choice Certification:	12/1/2023		
ENROLLEE HEALTH HISTORY			
Health Conditions/Diagnoses:	Extreme prematurity 25 Weeks gestation, Spina Bifida, Development Delay, Hydrocephaly (shunt in place), Dysphagia, Central Apnea, Gastrostomy Status, Weakness of the lower limbs, recurrent chronic UTIs, and history of Seizures. She is allergic to latex.		
Functional Status:	Jane requires assistance with all activities of daily living and ambulating. She has leg braces, a walker, and a wheelchair for mobility and is a one-person assist with transfers. She is incontinent of bowel and bladder and requires straight catheterization. A gastrostomy tube was placed to supplement Jane's nutritional intake. Jane eats a regular diet by mouth, but requires monitoring while eating and thickened liquids due to feeding difficulties. Jane has Central Apnea and requires a BiPap at night.		
Summary of Events that Led to Nursing Facility Admission:	Click or tap here to enter text.		

SAMPLE – FOR DISCUSSION PURPOSES ONLY

Skilled Nursing Facility Transition Plan

History of Service Utilization (e.g., ED, hospitalizations):	Shunt placement- 10/3/2017, Malfunction of shunt - 3/24/2018, placement of G-tube -7/15/2018, infection of subcutaneous tissue -11/20/2018, seizure 2/17/2019, pneumonia - 3/23/2019,			
Current Medications	Medication	Dose	Route	Frequency
	Oxybutynin	5 mg	By Mouth	Once a Day
	Amoxicillin	125 mg/5mL	By Mouth	Once a Day
	Levetiracetam	10 mg	By Mouth	Two times a Day
		Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Current Services (Including therapy services)	Service/Frequency		Provider Name & Telephone Number	
	Physical Therapy (twice a week)		Name of Provider-954-999-9999	
	Occupational Therapy (twice a week)		Name of Provider-954-999-9999	
	Speech Therapy (twice a week)		Name of Provider-954-999-9999	
	DME Equipment and Supplies		Name of Provider-954-999-9999	
	Nursing Facility Services Homebound School		Name of NF-954-999-9999	
Current Durable Medical Equipment (DME)/Supplies:	DME/Supplies		DME Provider Name & Telephone Number	

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

	Wheelchair	Name of Provider-954-999-9999
	AFO's	Name of Provider-954-999-9999
	Catheters and supplies	Name of Provider-954-999-9999
	Diapers and wipes	Name of Provider-954-999-9999
	BiPap Machine G-Tube feeding pump and supplies Shower Chair Walker	Name of Provider-954-999-9999 Name of Provider-954-999-9999 Name of Provider-954-999-9999 Name of Provider 954-999-9999
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))		
<input checked="" type="checkbox"/> 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.		
<input checked="" type="checkbox"/> 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.		
<input checked="" type="checkbox"/> 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.		
<input checked="" type="checkbox"/> 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.		
<input checked="" type="checkbox"/> 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): 1/2/2024)		
<input checked="" type="checkbox"/> 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:	1/15/2024	<input type="checkbox"/> Original <input checked="" type="checkbox"/> Update
Location of Meeting:	<input type="checkbox"/> In Person <input type="checkbox"/> Virtual <input checked="" type="checkbox"/> Phone	
Language Interpreter Offered:	Language Interpreter Used:	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A	
Participants Present (check all present and list names)		
<input type="checkbox"/> Enrollee:	N/A due to special medical condition	
<input checked="" type="checkbox"/> Parent/Guardian Name (Last, First) and Relationship to Enrollee:	Suarez, Janet (Mother) Suarez, Jose (Father)	

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<input checked="" type="checkbox"/> Managed Care Plan Care Coordinator and/or other Plan Staff:	Managed Care Plans Coordinator's Name
<input type="checkbox"/> Managed Care Plan Medical Staff:	N/A
<input checked="" type="checkbox"/> Nursing Facility Care Coordinator:	Nursing Facility Coordinator's Name
<input type="checkbox"/> Nursing Facility Staff – Other:	N/A
<input type="checkbox"/> Primary Care Physician:	N/A
<input type="checkbox"/> Specialty Physician:	N/A
<input type="checkbox"/> DCF Representative <input checked="" type="checkbox"/> N/A	Click or tap here to enter text.
<input type="checkbox"/> Other(s) (Relationship(s) to Recipient):	N/A
<input type="checkbox"/> Parent(s)/Guardian(s) unable to be reached after three attempts (Date follow up information mailed to parent(s)/guardian(s): Click or tap to enter a date.) <input type="checkbox"/> Parent(s)/Guardian(s) declined to participate in transition plan meeting (Date follow up information mailed to parent(s)/guardian(s): Click or tap to enter a date.) <input type="checkbox"/> Parent(s)/Guardian(s) agreed to participate but not present at time of meeting (Date follow up information mailed to parent(s)/guardian(s): Click or tap to enter a date.	

Service Definitions

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

Service	Description
Care Coordination	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> One-on-one, medically necessary nursing care from a 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	<ul style="list-style-type: none"> Items for every day, or extended use at home, including: <ul style="list-style-type: none"> Ventilation equipment and supplies Oxygen equipment and supplies Feeding equipment and supplies Mobility devices such as a wheelchair
Medical Transportation	<ul style="list-style-type: none"> Non-emergency Medical Transportation for your child and a caregiver to medical appointments
Prescribed Pediatric Extended Care (PPEC)	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> A program for children through age 20

SAMPLE – FOR DISCUSSION PURPOSES ONLY

Skilled Nursing Facility Transition Plan

	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Benefits that are offered by your health plan, in addition to the standard benefit package, such as transition assistance and housing assistance.
Developmental Disabilities Individual Budgeting (iBudget) Waiver Program	<ul style="list-style-type: none"> • The iBudget Waiver Program 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: <ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> • Long Term Care Waiver Program: <ul style="list-style-type: none"> ○ 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

SAMPLE – FOR DISCUSSION PURPOSES ONLY

Skilled Nursing Facility Transition Plan

	<ul style="list-style-type: none">○ 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:<ul style="list-style-type: none">○ 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:<ul style="list-style-type: none">▪ 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:<ul style="list-style-type: none">▪ 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<ul style="list-style-type: none">○ 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<ul style="list-style-type: none">▪ 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
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SAMPLE – FOR DISCUSSION PURPOSES ONLY

Skilled Nursing Facility Transition Plan

	<ul style="list-style-type: none">○ This waiver is only available to Medicaid recipients that are fee-for-service
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SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

* If needed, additional fields can be added to care plan sections by clicking the “+” to the right of the text box (see example image below) or by pressing “enter”.



PARENT/GUARDIAN CHOICE OF SETTING					
<input checked="" type="checkbox"/> I want my child to come home or move to a community setting <input type="checkbox"/> 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 <input type="checkbox"/> 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. <input checked="" type="checkbox"/> every 3 months <input type="checkbox"/> every 6 months <input type="checkbox"/> every 9 months <input type="checkbox"/> every 12 months					
Date & Place of Proposed Discharge (including address, if known): (02/29/2024, 1110 Seasonal Street Miami Gardens, FL 33014) <input type="checkbox"/> N/A					
PARENT(S)/GUARDIAN(S)/ENROLLEE’S GOALS AND BARRIERS					
Goals for Child’s Placement: The parents want their daughter home so she can enjoy family time, including meals with extended family, church gatherings, walks, and day trips to the beach.					
Barriers to Child’s Transition: The parents expressed they do not know what steps are needed to take to transition their daughter home and indicated they are getting different information from the care team.					
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 <input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s)	The parents will verbalize understanding of the enhanced care coordination service and how the process	N/A – There are no barriers to this goal.	Inform the parents of all services and supports that are available to the member, identifying specific community resources; documenting	Care Coordinator	As needed

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<input checked="" type="checkbox"/> Other coordination/support to assist in transitioning	<p>facilitates the transition of member from the nursing facility to their home.</p> <p>Click or tap here to enter text.</p> <p>Click or tap here to enter text.</p> <p>Click or tap here to enter text.</p> <p>Click or tap here to enter text.</p> <p>Click or tap here to enter text.</p>	<p>Click or tap here to enter text.</p> <p>Click or tap here to enter text.</p>	<p>and addressing all barriers to transition. Parents will be given a copy of the transition plan. </p> <p>Communicate with the parents and liaise with the CMAT, the nursing facility, providers, schools, and other state agencies or organizations to facilitate services and supports required for successfully transitioning member from the nursing facility to the parent’s home.</p> <p>Identify medications and services that require an order (prescription from the PCP or specialist) and/or a referral, authorization from the insurance plan, and explain the authorization process as applicable, including the grievance, appeal and fair hearing process.</p>	<p>Click or tap here to enter text.</p> <p>Care Coordinator</p>	<p>As needed</p>
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SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

			<p>Assist the parents in obtaining a current medication list and required prescriptions prior to the member’s discharge and arrange for pick up or delivery upon discharge.</p> <p>Coordinate with home health agencies, nurses, and other medical providers for continuity of care.</p>		
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)
<p>Private Duty Nursing (PDN)</p> <p><input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s)</p> <p><input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered</p> <p><input checked="" type="checkbox"/> Home visits to other family homes offered where children are receiving PDN services, if applicable (see below)</p>	<p>Identify individual PDN needs and schedule PDN to begin services by the member’s discharge from the nursing facility.</p>	<p>- Home health agency availability</p> <p>-Finding the right RN/LPNs that “fit” the needs of the family</p>	<ol style="list-style-type: none"> Obtain order Identify home health agency Home health agency to complete intake and assessment Home health agency to identify available nurses Home health agency to submit a service authorization Home health agency receives 	<ol style="list-style-type: none"> Care Coordinator to work with PCP Care Coordinator to provide family with provider options and family selects home health agency of their choice 	<ol style="list-style-type: none"> 1/25/2024 2/1/2024 2/5/2024 2/9/2024 2/9/2024 2/20/2024 2/20/2024 Upon discharge

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<input checked="" type="checkbox"/> Family-to-family peer support offered from a family that has received PDN for a child with complex medical needs, if applicable (see below) <input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition			authorization approval 7. Services are to be scheduled 1 to 2 weeks prior to the date of discharge 8. Services begin	3. Home health agency 4. Home health agency works with family 5. Home health agency 6. Health Plan 7. Home health agency 8. Home health agency	
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)
Medical Equipment and Supplies <input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s) <input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered	DME and supplies ordered and scheduled to be delivered upon discharge: - Wheelchair - Shower Chair - AFO's - Continenence Supplies - Catheters and Supplies -BiPap	- None identified at this time.	1. Obtain order 2. Identify DME Provider(s) 3. Provider to submit a service authorization 4. Provider receives authorization approval 5. Supplies delivered	1. Care Coordinator to work with PCP 2. Care Coordinator to provide family with DME company options and family selects	1. 1/25/2024 2. 2/1/2024 3. 2/5/2024 4. 2/9/2024 5. Prior to discharge

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition	-G-tube pump and supplies -Walker			provider of their choice 3. DME Company 4. Health Plan 5. DME Company	
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)
Medical Transportation <input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s) <input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered <input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition	Member requires reliable and secure transportation to accommodate medical needs and equipment for maintaining stable health	There is a high demand of specialized/ medical transportation The parents share one vehicle.	Member's family needs to contact and schedule transportation service with MMA at least 72 hours in advance of any appointment. Provide updated and reliable contacts of transportation providers to supplement the member's transportation needs to medical appointments.	Care Coordinator and Parents	As needed As needed
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<p>Prescribed Pediatric Extended Care (PPEC)</p> <p><input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s)</p> <p><input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered</p> <p><input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition</p>	<p>Parents will verbalize understanding regarding PPEC benefits that include an alternative environment and specialized nursing supervision.</p> <p>Provide the parent/guardian with updated and reliable contacts of PPEC providers in the area capable to cover member's needs</p>	<p>Location of the facility is not always in close proximity of the member's home.</p>	<ol style="list-style-type: none"> 1. Obtain order 2. Provide parent's list of PPEC providers in the area to assist in identification of a provider 3. Provider to submit a service authorization 4. Provider receives authorization approval 5. Services begin 	<p>Parents, Care Coordinator</p>	<ol style="list-style-type: none"> 1. 1/25/2024 2. 2/1/2024 3. 2/5/2024 4. 2/9/2024 5. 2/9/2024
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)
<p>Medical Foster Care</p> <p><input type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s)</p> <p><input type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered</p> <p><input type="checkbox"/> Needed for Transition</p>	<p>There are no goals or needs for this service at this time.</p>	<p>None at this time</p>	<p>No action is needed for this member.</p>	<p>None</p>	<p>N/A</p>

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<input checked="" type="checkbox"/> Not Needed for Transition					
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)
Expanded Benefits <input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s) <input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered <input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition	Educate parents on the expanded benefits offered by the health plan, including the \$25 for OTC medication.	None	Provide member’s parents with information needed via mail, email, or brochure to take advantage of all the benefits needed. Call providers in the service area and connect them with the member's parents. Provide contact information of local community resource offices.	Parents, Care Coordinator Care Coordinator	1/25/2024 As needed
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)
Developmental Disabilities Individual Budgeting (iBudget) Waiver Program <input checked="" type="checkbox"/> Individualized education provided to parent(s)/guardian(s) about services required under iBudget:	Apply for iBudget waiver for home modifications and therapies, services, and other supports/benefits to supplement those provided by the health.	Obtaining all the documentation needed for the application. Lengthy application	Verify member's diagnosis for qualification into the program. Begin obtaining testing records. Follow-up on application status every month.	Care Coordinator, Parents Care Coordinator, Parents	1/25/2024 2/3/2024

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<input checked="" type="checkbox"/> Home Modifications <input type="checkbox"/> Vehicle Modifications <input checked="" type="checkbox"/> Consumable Medical Supplies <input checked="" type="checkbox"/> Respite <input checked="" type="checkbox"/> Occupational Therapy <input checked="" type="checkbox"/> Speech Therapy <input checked="" type="checkbox"/> Physical Therapy <input type="checkbox"/> Respiratory Therapy <input type="checkbox"/> Behavior Analysis Services <input checked="" type="checkbox"/> Private Duty Nursing <input checked="" type="checkbox"/> Life Skills Development <input checked="" type="checkbox"/> Dietitian Services <input checked="" type="checkbox"/> Personal Emergency Response System <input checked="" type="checkbox"/> Skilled Nursing <input checked="" type="checkbox"/> Specialized Medical Equipment & Supplies <input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered <input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition		approval process	Obtain iBudget waiver (APD) authorization approval.		
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SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

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Other Florida Medicaid Waiver Programs <input type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s) <input type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered <input type="checkbox"/> Needed for Transition <input checked="" type="checkbox"/> Not Needed for Transition	None at this time	None at this time	None at this time	None at this time	N/A
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)
Additional Services and Supports <input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s) <input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered	Physical Therapy 2x per week Occupational Therapy 2x per week Speech Therapy 2x per week	To be identified once therapy service delivery setting (outpatient, home health, school, etc.) is ordered by the primary care provider.	1. Obtain orders for all therapies (PT, OT, ST) 2. Provide parent’s list of PPEC providers in the area to assist in identification of a provider		

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition			3. Provider to submit a service authorization 4. Provider receives authorization approval 5. Services begin		
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)
Family-to-Family Home Visits <input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s) <input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered <input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition	Provide the parents an opportunity to observe PDN services provided in the home and ask questions.	Availability, time constraints	Identify volunteer families interested in hosting Family-to-Family Home visits. Contact the hosting family to schedule the visit.	Care Coordinator, Parents	2/3/2024
Service	Goal(s)/Need(s)	Barrier(s)	Action(s) Needed	Responsible Person(s)	Due Date(s)

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

<p>Family-to-Family Peer Support</p> <p><input checked="" type="checkbox"/> Education and individualized information about this service provided to parent(s)/guardian(s)</p> <p><input checked="" type="checkbox"/> Outreach to connect parent(s)/ guardian(s) to services offered</p> <p><input checked="" type="checkbox"/> Needed for Transition <input type="checkbox"/> Not Needed for Transition</p>	<p>Provide the parents an opportunity to learn about the PDN services from a family already receiving the services to have the opportunity to talk about experiences and ask questions. This can be done over the phone.</p>	<p>Availability, time constraints</p>	<p>Identify volunteer families interested in hosting peer-to-peer services for the enrollees. Encourage families to support others with similar lived experiences.</p> <p>Identify volunteer families interested in hosting peer-to-peer services for the enrollees.</p>	<p>Care Coordinator, Parents</p>	<p>2/3/2024</p> <p>2/3/2024</p>
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Referral Information

Name of person receiving referral:	Reason why referral was made:	Date of referral:
Name of Physical Therapy Provider	Child has orders for physical therapy, 2 times per week	TBD
Name of Occupational Therapy Provider	Child has orders for occupational therapy, 2 times per week	TBD
Name of Speech Therapy Provider	Child has orders for speech therapy, 2 times per week	TBD
Name of DME Equipment and Supplies	Child has orders for DME equipment and supplies therapy	TBD

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

Name of School receiving IEP Referral	Child will require an IEP	2/1/2024
Name of PDN Provider	To be chosen from available options	TBD
Name of PPEC Provider	To be chosen from available options	TBD
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Enter any content that you want to repeat, including other content controls. You can also insert this control around table rows in order to repeat parts of a table.	Click or tap here to enter text.	Click or tap here to enter text.

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)
Plan for Home Evaluation and Modifications	Assess the home environment to ensure adequate space and to address any barriers.	Family needs to widen three doorways and modify the bathroom to meet the daughter’s mobility needs – before discharge home.	Schedule Home Evaluation with parents and address any barriers to transition.	Care Coordinator, Parents	2/25/24
Educate and provide support to the parents on the child’s diagnosis, treatments, care and support groups.	Parents will develop and enhance their knowledge of the enrollee’s medical conditions, risks, treatments, and situations in which to	Parents have gaps in knowledge of the child’s medical conditions and care.	Assess and address current gaps in knowledge.	Care Coordinator Parents	1/29/24

SAMPLE – FOR DISCUSSION PURPOSES ONLY
Skilled Nursing Facility Transition Plan

	<p>contact the enrollee’s medical providers and seek urgent and emergent care.</p> <p>Parents will be able to meet the child’s care and treatment needs.</p> <p>Parents will be trained in CPR and obtain certification.</p>		<p>Review care and treatment plans with parents.</p> <p>Provide training to parents in the child’s care</p> <p>Provide educational literature on medical conditions and treatments/care.</p> <p>Identify and provide local Spina Bifida Resources and information on support groups.</p>		
Plan for Individualized Education Program (IEP) support service for homebound	An IEP will be implemented for member.	Parents are undecided on which school they want to place the member.	Identify school and community resources.	Care Coordinator, Parents	2/9/2024
Discuss and review Pathway to Prosperity program	Educate parents on the benefits provided in the program.	No barriers to this goal.	Assist parents in reviewing eligibility requirements and applying to the program.	Care Coordinator, parents	1/17/2024
Explore enrollment in the Consumer-Directed Care CDC+ Program under the iBudget Waiver	Parents will have the information they need regarding program enrollment and determine if this option will support them in caring for the member at home.	This program is offered under the iBudget program. The member must first be enrolled in the iBudget Waiver.			

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Skilled Nursing Facility Transition Plan

TRANSITION PLAN NOTES/SUMMARY	
<p>The parents were in attendance at the transition meeting and were receptive to the information received. Parents continue to express their intent to transition the child from the nursing facility to their home and the Care Coordinator is actively working with the parents, providers, and the other organization's representatives for transitioning the child, and addressing the parents concerns and barriers. The parents were educated on the transition plan process, training in the child's care, medications, equipment, supplies, services to meet the child's care, and community supports, including information for Spina Bifida resources. Follow-up items will continue to be addressed and the transition plan will be updated as necessary. The Care Coordinator will continue to work alongside the parents and providers for transition plan updates, execution, and implementation. The parents were provided written information on all the services and supports needed for transition of member in addition to a copy of this transition plan. Weekly meetings will be held with parents to monitor and review status of outstanding items for transitioning the enrollee from the nursing facility to the parent's home.</p>	

SIGNATURES			
Enrollee Signature:	N/A	Date:	N/A
Parent/Guardian Signature:	Signature of Janet and Jose Suarez	Date:	1/15/2024
Managed Care Plan Care Coordinator Signature:	Signature of the Managed Care Plan Care Coordinator	Date:	1/15/2024
Nursing Facility Care Coordinator Signature:	Signature of the Nursing Facility Coordinator Care Coordinator	Date:	1/15/2024