Skilled Nursing Facility Transition Plan

ENROLLEE INFORMATION			
Enrollee's Name (Last, First):	Click or tap here to enter text.		
Enrollee's Medicaid ID Number:	Click or tap here to enter text.	Date of Birth:	Click or tap here to enter text.
Managed Care Plan:	Click or tap here to enter text.	Enrollee's Age:	Click or tap here to enter text.
Care Coordinator (Last, First):	Click or tap here to enter text.		
Care Coordinator's Phone Number:	Click or tap here to enter text.		
Name of Current Nursing Facility:	Click or tap here to enter text.	Admission Date:	Click or tap here to enter text.
Current Nursing Facility's Address:	Click or tap here to enter text.		
Current Nursing Facility's Phone Number:	Click or tap here to enter text.		
Date of Nursing Facility Admission:	Click or tap here to enter text.		
Parent/Guardian's Name(s) (Last, First):	Click or tap here to enter text.		
Relationship to Enrollee:	Click or tap here to enter text.		
Address:	Click or tap here to enter text.		
Phone Number(s):	Click or tap here to enter text.		
Email Address(es):	Click or tap here to enter text.		
Preferred Language:	Click or tap here to enter text.		
Preferred Method of Contact:	Click or tap here to enter text.		
Date of Last Freedom of Choice Certification:	Click or tap to enter a date.		

ENROLLEE HEALTH HISTORY				
Health Conditions/Diagnoses:	Click or tap here to enter text.			
Functional Status:	Click or tap here to enter text.			
Summary of Events that Led to Nursing Facility Admission:	Click or tap here to enter text.			
History of Service Utilization (e.g., ED, hospitalizations):	Click or tap here to enter text.			
Current Medications	Medication	Dose	Route	Frequency
	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.
	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.
	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.
	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	
	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 Durable Medical Equipment (DME)/Supplies:	DME/Supplies		DME Provider Name & Telephone Number	
	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.	

Skilled Nursing Facility Transition Plan

	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.

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): Click or tap to enter a date.

☐ 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:	Click or tap to enter a date.	☐Original ☐Update
Location of Meeting: ☐ In Person ☐ Virtual ☐ Phone		
Language Interpreter Offered: ☐Yes ☐N/A	Language Interpreter Used: ☐Yes ☐No ☐N/A	

Participants Present (check all present and list names)

☐ Enrollee:	Click or tap here to enter text.
☐ Parent/Guardian Name (Last, First) and Relationship to Enrollee:	Click or tap here to enter text.
☐ Managed Care Plan Care Coordinator and/or other Plan Staff:	Click or tap here to enter text.
☐ Managed Care Plan Medical Staff:	Click or tap here to enter text.
☐ Nursing Facility Care Coordinator:	Click or tap here to enter text.
☐ Nursing Facility Staff – Other:	Click or tap here to enter text.
☐ Primary Care Physician:	Click or tap here to enter text.
☐ Specialty Physician:	Click or tap here to enter text.

Skilled Nursing Facility Transition Plan

☐ DCF Representative ☐ N/A	Click or tap here to enter text.
☐ Other(s) (Relationship(s) to Recipient):	Click or tap here to enter text.

☐ 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.

☐ 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.

☐ 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	• 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 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, such as transition assistance and housing assistance.

Developmental Disabilities Individual Budgeting (iBudget) Waiver Program	• 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:
	  ○ 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 o Services include: ▪ Assistive Technology and Service Evaluation ▪ Environmental Accessibility Adaptations ▪ Respite ▪ Transition Case Management o This waiver is only available to Medicaid recipients that are fee-for-service • Familial Dysautonomia Waiver Program o 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 o 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 o This waiver is only available to Medicaid recipients that are fee-for-service

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".*

Click or tap here to enter text.

PARENT/GUARDIAN CHOICE OF SETTING
☐ I want my child to come home or move to a community setting • The next Transition Planning Process will occur within **three** (3) months. ☐ 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 • The parent/guardian requests the Transition Planning Process be reinitiated within the timeframe below (choose one): ☐ Three (3) months ☐ Six (6) months ☐ I want my child to stay in a nursing facility and oppose my child living at home or in a community setting • The parent/guardian requests the Transition Planning Process be reinitiated within the timeframe below (choose one): ☐ Three (3) months ☐ Six (6) months ☐ Nine (9) months ☐ One (1) year ☐ The parent/guardian did not participate in the Transition Planning Process • The Transition Planning Process must be reinitiated: ☐ Within the frequency period most recently selected by the parent/guardian ☐ Within three (3) months if a parent/guardian has never expressed a frequency preference ☐ Within six (6) months if a parent/guardian has never expressed a frequency preference, and the parent/guardian declined to participate in—or agreed to participate but did not participate in—the two most recent Transition Planning Processes Approximate date of next Transition Planning Process: Click or tap here to enter text.
~~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): (Click or tap here to enter text.)

☐ N/A					
PARENT(S)/GUARDIAN(S)/ENROLLEE'S GOALS AND BARRIERS					
Goals for Child's Placement: Click or tap here to enter text.					
Barriers to Child's Transition: Click or tap here to enter text.					
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 service provided to parent(s)/guardian(s) ☐ Other coordination/support to assist in transitioning	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.
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	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.

☐ 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					
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	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.
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	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.
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	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.
Service	**Goal(s)/Need(s)**	**Barrier(s)**	**Action(s) Needed**	**Responsible Person(s)**	**Due Date(s)**
Medical Foster Care	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

☐ 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					to enter text.
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	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.
Service	**Goal(s)/Need(s)**	**Barrier(s)**	**Action(s) Needed**	**Responsible Person(s)**	**Due Date(s)**
Developmental Disabilities Individual Budgeting (iBudget) Waiver Program ☐ Individualized education provided to parent(s)/guardian(s)	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.

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					
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	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.
Service	**Goal(s)/Need(s)**	**Barrier(s)**	**Action(s) Needed**	**Responsible Person(s)**	**Due Date(s)**
Additional Services and Supports *This includes services such as physical therapy, occupational therapy, and speech therapy* ☐ Education and individualized information about ~~this~~ additional services and supports provided to parent(s)/guardian(s) ☐ Outreach to connect parent(s)/ guardian(s) to services offered ☐ Needed for Transition ☐ Not Needed for Transition	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.

Skilled Nursing Facility Transition Plan

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	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.
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	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.

Referral Information

Skilled Nursing Facility Transition Plan

Name of person receiving referral:	Reason why referral was made:	Date of referral:
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.
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.
Click or tap here to enter text.	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)**
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.

Skilled Nursing Facility Transition Plan

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.
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.
TRANSITION PLAN NOTES/SUMMARY					
Click or tap here to enter text.					

SIGNATURES			
Enrollee Signature:	X	Date:	Click or tap to enter a date.
Parent/Guardian Signature:	X	Date:	Click or tap to enter a date.

Skilled Nursing Facility Transition Plan

Managed Care Plan Care Coordinator Signature:	X		Date:	Click or tap to enter a date.
Nursing Facility Care Coordinator Signature:	X		Date:	Click or tap to enter a date.