COLORADO
CHOICE TRANSITIONS
YOUR PATH TO INDEPENDENCE

PLAN FOR COMMUNITY LIVING GUIDE

CLIENT NAME _____

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For additional copies please contact CCT Community Liaison at
303-866-2649 or send a request to CCT@hcpf.state.co.us

Department of Health Care Policy and Financing
1570 Grant Street Denver, Colorado 80203

OVERVIEW

You have made the choice to explore the option of moving to the community, now the transition assessment process will begin. In this step of your transition you will be asked to complete this **Plan for Community Living guide**.

By completing this guide you will:

- Gain a more detailed understanding of your wants and needs for community living
- Decide how you want to live in the immediate future
- Exercise control and make choices in your decisions about community living
- Allow your transition options team to understand your desires and needs for community living so that they can better help you
- Provide information that will determine how much time is needed to transition to the community

On the next page you will find the chart for the transition assessment planning steps. In this book you are going to cover **step three** highlighted in **BLUE**.

STEPS OF THE TRANSITION PROCESS

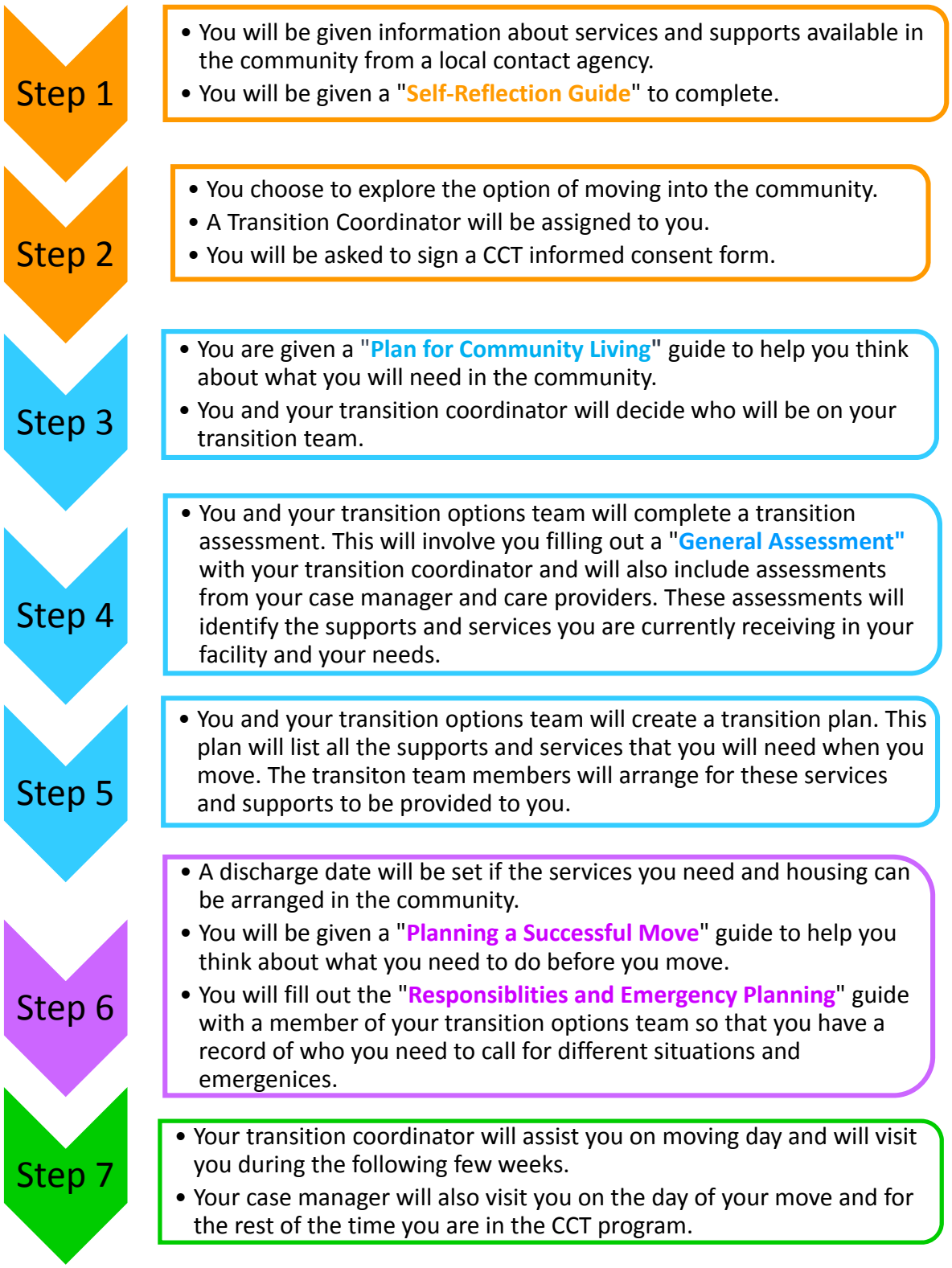

Figure 1. Steps of Transition Process

SERVICES AND BENEFITS

Before you fill out your Plan for Community Living, please take a moment to read about how this plan will be used below.

The needs identified through this plan and the assessment process (Figure 1) will be matched to services, housing and funding available in the community. Your transition coordinator, case manager and long-term care facility staff will be involved in determining availability of services required for your move.

You will have the opportunity to review, discuss and participate in the selection of available housing options. Your case manager and transition coordinator will assist you with choosing the right agencies that will provide the services you may need in the community. You and your transition coordinator will work very closely with other members of your transition options team, who will assist you with each step of the transition plan and keep track of everything that has to happen to create a safe and successful move.

All of the community-based services you will need must be in place prior to your move. Your transition coordinator will be available to support, problem-solve and encourage you during your first weeks in your new home. Your case manager will continue to provide support and services to you on an on-going basis during the 365 days you are enrolled in the CCT program.

PLAN FOR COMMUNITY LIVING

Please complete each section below. Note that some of the categories listed in this section may not apply to you, if that is the case you can skip them. Be sure to discuss any skipped sections with your transition coordinator.

FAMILY AND FRIENDS

1. Do you have friends or family members that you talk to or see on a regular basis?

   ☐ Yes. If so, who? _____
   ☐ No

Comments:

_____

_____

2. Are visits from family and friends important to you?

   ☐ Yes
   ☐ No

Comments:

_____

_____

If the answers to questions 1 and 2 are "No" you may skip to the **Housing Choices Section**

3. How often do you see or talk with friends and family members?

   ☐ Daily
   ☐ Weekly
   ☐ Other. Please explain._____

4. Are any of your friends or family members able to make decisions for you (either medically or financially)?

   ☐ Yes. If so, who? _____
   ☐ No

Comments:

_____

_____

5. Do your friends or family members agree with your move to a community setting?

   ☐ Yes
   ☐ No - Please explain _____
   ☐ Unsure - Please explain. _____

Comments:

_____

_____

6. Who is the family member or friend that you trust most to help you plan for your move? _____

7. Do you have friends or family who you can go to for help in the following areas: setting up appointments, transportation, moving you into your new home?

   ☐ Yes
   ☐ No

Comments:

_____

_____

HOUSING CHOICES

1. What would be your ideal living setting?
   (Check **all** that apply to you)
   ☐ Alone
   ☐ With family. If so, who? _____
   ☐ With a host family
   ☐ With someone else. If so, who? _____
   ☐ With pet
   ☐ Other_____

If you identified someone above that you would like to live with does this person want to live with you?

   ☐ Yes
   ☐ No
   ☐ Unsure

Comments:

_____

_____

2. Have you lived alone in the past?

☐ Yes
☐ No

If yes, what did you like about living alone? _____

_____

What did you dislike about living alone? _____

_____

3. Would you prefer to live near friends or family members?

☐ Yes
☐ No

If yes, who are they? _____

Where do they live? _____

Comments: _____

_____

4. Would you prefer to live:

☐ In a house
☐ In an apartment
☐ Other_____

Comments:

_____

_____

5. Would you prefer to live:

- ☐ In town
- ☐ Near a bus line
- ☐ In a suburb
- ☐ In a rural setting
- ☐ Other _____

Comments:

_____

_____

6. Will you need home modifications (e.g. a ramp, modified bath room)?

- ☐ Yes. Describe needed modifications_____
- ☐ No
- ☐ Unsure. Please explain _____

Comments:

_____

_____

7. Do you have funds to pay for housing?

- ☐ Yes
- ☐ No
- ☐ Unsure

Comments:

_____

_____

8. Do you enjoy having neighbors?

☐ Yes
☐ No

Comments:

_____

_____

9. Would you prefer to live in a community without children?

☐ Yes
☐ No

Comments:

_____

_____

10. What other things are important to you in regard to housing?

_____

_____

_____

11. What are your thoughts, concerns, questions about housing?

_____

_____

_____

_____

PERSONAL CARE NEEDS

You will be asked about your medical needs as part of your General Assessment. This section will help you plan for your personal care needs.

1. Will you need help with any of the following?
   (Check **any** that apply to you)

   ☐ No, I do not need help with any of the following tasks.
   ☐ Yes, I need help with the following:
      ☐ Getting in or out of bed
      ☐ Getting in or out of the tub
      ☐ Getting in or out of a wheelchair
      ☐ Getting on or off the toilet
      ☐ Getting on or off a couch or chair
      ☐ Other: _____

I will need help (Check **all** that apply):

___ Morning ___ Afternoon ___ Evening ___ Nighttime

Comments:

_____

_____

_____

_____

_____

_____

2. Will you need assistance with your medication after you move?
   (Check **any** that apply to you)

   ☐ No, I do not need assistance with medications.
   ☐ Yes, I need help with the following:
      ☐ Opening the bottles
      ☐ Taking the medication
      ☐ Setting up medications
      ☐ Ordering medications
      ☐ Other: _____

I will need help (Check **all** that apply):

___ Morning ___ Afternoon ___ Evening ___ Nighttime

Comments:

_____

_____

3. Will you need nighttime assistance?
   (Check **any** that apply to you)

   ☐ No, I do not need nighttime assistance.
   ☐ Yes, I need help with the following:
      ☐ Turning/Repositioning
      ☐ Monitoring
      ☐ Other_____

Comments:

_____

_____

4. Will you need help with any of the following?
   (Check **all** that apply to you)

   ☐ No, I do not need help with any of the following tasks.
   ☐ Yes, I need help with the following:
      ☐ Getting dressed or undressed
      ☐ Taking a bath or a shower
      ☐ Using the toilet
      ☐ Washing your hair
      ☐ Brushing your teeth
      ☐ Other: _____

I will need help (Check **all** that apply):

___ Morning ___ Afternoon ___ Evening ___ Nighttime

Comments:

_____

_____

ACCOMPLISHING DAILY NEEDS

1. Do you have trouble remembering to do things?

   ☐ Yes
   ☐ No

Comments:

_____

_____

2. Will you need help with your meals?

- ☐ No, I do not need help with my meals.
- ☐ Yes, I need help with the following:
  - ☐ Planning meals
  - ☐ Shopping for meals
  - ☐ Fixing meals
  - ☐ Eating meals
  - ☐ Cleaning up after fixing meals
  - ☐ Storing food
  - ☐ Other: _____

I will need help (Check **all** that apply):

___ Hourly ___ Daily ___ Weekly ___ Monthly

3. Will you need help with your laundry?

- ☐ No, I do not need help with my laundry.
- ☐ Yes, I need help with the following:
  - ☐ Washing laundry
  - ☐ Drying laundry
  - ☐ Folding laundry
  - ☐ Putting laundry away
  - ☐ Ironing
  - ☐ Sewing or minor repairs, such as sewing on buttons
  - ☐ Other: _____

I will need help (Check **all** that apply): ____ Daily ____ Weekly

4. What challenges do you see for yourself with the following tasks?

Housekeeping:

Dusting: _____

Vacuuming: _____

Washing the dishes: _____

Cleaning the bathroom: _____

Cleaning the kitchen: _____

Other: _____

Home Maintenance or Minor Repairs:

Mowing the lawn: _____

Shoveling snow: _____

Changing light bulbs: _____

Emptying the trash: _____

Recycling: _____

Setting out/bringing in the trash or recycling bins: _____

Other: _____

5. Will you need help shopping for any of the following?

☐ No, I do not need help shopping.

☐ Yes, I need help with the following:

- ☐ Clothes
- ☐ Household items
- ☐ Other: _____

I will need help: ____ Daily ____ Weekly ____ Monthly

6. Will you need assistance to obtain household items such as linens, dishes, pots/pans etc.?

   ☐ Yes
   ☐ No

7. What household items do you have?

   _____

   _____

8. What household items will you need?

   _____

   _____

9. Will you need to acquire furniture for your new home?

   ☐ No
   ☐ Yes. If so, please list items needed below

COMMUNICATION NEEDS

List specific communication needs, for example, sign-language interpreting (what mode), communication technologies or preferences, etc._____

_____

1. Will you need the assistance of an interpreter?

   ☐ Yes
   ☐ No

2. Do you use an interpreter currently?

   ☐ No
   ☐ Yes. If yes, please provide their contact information

Interpreter name _____

Phone number _____

TRANSPORTATION CHOICES

1. What type of transportation do you use? (Check all that apply)

   ☐ Public transportation (such as a bus)
   ☐ Access-a-ride
   ☐ Friends/Family
   ☐ Wheelchair accessible bus or van
   ☐ Personal assistant to drive
   ☐ None
   ☐ Other _____

2. How often will you use transportation?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly

Comments:

_____

_____

3. Will you need help obtaining or accessing transportation?

- ☐ Yes
- ☐ No

Comments:

_____

_____

4. Will you need assistance transferring in and out of a vehicle?

- ☐ Yes
- ☐ No

Comments:

_____

_____

5. Are you interested in learning how to access public transportation?

- ☐ Yes
- ☐ No

Comments:

_____

_____

6. Do you have a current driver's license?

☐ Yes
☐ No

Comments: _____

7. Are you interested in obtaining a driver's license?

☐ Yes
☐ No

Comments: _____

8. Do you need assistance to obtain a driver's license?

☐ Yes
☐ No

Comments: _____

9. Do you own a vehicle?

☐ Yes
☐ No

Comments:

_____

_____

Do you have any thoughts or concerns about anything you have answered about transportation? Please explain: _____

_____

_____

FINANCES

1. Does the facility you currently live in keep money for you?

   ☐ Yes
   ☐ No

Comments:

_____

_____

2. Do you have experience creating a budget and paying bills?

   ☐ Yes
   ☐ No

Comments:

_____

_____

3. Do you have someone that helps you pay your bills and manage your money? For example a representative payee.

   ☐ Yes
   ☐ No

Comments:

_____

_____

4. When you move, will you need help managing your finances (such as budgeting, paying bills, getting cash, etc.?)

   ☐ Yes - what will you need help with? _____
   ☐ No

5. Would you like more information about other possible financial help when you move?

   ☐ Food Stamps
   ☐ Heating assistance
   ☐ Phone bill assistance
   ☐ Vocational Rehabilitation (Employment Assistance)
   ☐ Other _____

6. Do you have any current debts or bills?

   ☐ Yes. If so, list the amount $_____
   ☐ No

7. Will you need assistance to resolve past or present credit issues or problems?

   ☐ Yes
   ☐ No

Comments:

_____

_____

8. Will you need assistance to develop a monthly budget?

   ☐ Yes
   ☐ No

Comments:

_____

_____

EMPLOYMENT AND VOLUNTEERING

1. Are you interested in getting a job after you move?

   ☐ Yes
   ☐ No

Comments:

_____

_____

2. Have you had a job before?

   ☐ Yes. What kind of work did you do? _____
   ☐ No

Comments:

_____

_____

3. Would you like to find work similar to what you did before?

   ☐ Yes
   ☐ No

Comments:

_____

_____

4. Would you like to do volunteer work in the community?

   ☐ Yes. If yes, where_____
   ☐ No

Comments:

_____

_____

5. Will you need help finding and applying for employment or volunteer opportunities?

   ☐ Yes
   ☐ No

Comments:

_____

_____

6. Will you need assistance while working or volunteering?

   ☐ Yes
   ☐ No

   If so, how often _____Weekly _____ Daily _____Continuously

Comments:

_____

_____

LEGAL ISSUES

1. Will you need assistance resolving past legal issues?

   ☐ Yes, if so, please explain: _____
   ☐ No

Comments:

_____

_____

_____

_____

PARENTING

1. Do you have parenting/child care responsibilities?

   ☐ Yes, if so, please explain: _____
   ☐ No

Comments:

_____

_____

2. Are you interested in receiving parent education?

   ☐ Yes
   ☐ No

Comments:

_____

_____

3. Will you need special equipment for children?

   ☐ Yes, if so, please explain: _____
   ☐ No

Comments:

_____

_____

TRAININGS

1. Are you interested in taking assertiveness training to help you advocate for yourself in the community?

   ☐ Yes
   ☐ No

Comments: _____

_____

2. Do you need support in learning how to manage your personal care attendants?

   ☐ Yes
   ☐ No

Comments: _____

_____

3. Do you need training on the use of assistive technology such as smart phones, iPads, and internet safety?

   ☐ Yes
   ☐ No

Comments: _____

_____

PERSONAL ACTIVITIES

1. Do you know how to use the Internet?

   ☐ Yes
   ☐ No

Comments:

_____

_____

2. What activities would you like to participant in when you move?
   (Check all that apply to you)

   ☐ Go to restaurants
   ☐ Go to the movies
   ☐ Go to sporting events
   ☐ Go shopping
   ☐ Go for walks
   ☐ Go bowling
   ☐ Watch TV
   ☐ Read
   ☐ Listen to music
   ☐ Play cards or games
   ☐ Swim
   ☐ Attend community events
   ☐ Other _____

3. When you do activities, do you prefer doing them:

   ☐ Alone
   ☐ With groups
   ☐ With family or friends
   ☐ Unsure

4. Do you belong to any clubs or organizations?

☐ No
☐ Yes. Which ones? _____
☐ I would like to get involved in clubs or organizations after I move.

Comments:

_____

_____

5. Do you belong to a church, synagogue, mosque or a religious group or organization?

☐ No
☐ I would like to join one after I move.
☐ Yes. Which one? _____

If so, would you still like to attend services at your current place?

☐ No
☐ Yes
☐ I would be willing to find another place closer to my new home

Comments:

_____

_____

You will fill out the last section of this guide with your transition coordinator.

Please read ahead so that you are prepared.

GENERAL ASSESSMENT

Now that you have thought through your vision for community living and your transition needs, please take the time to fill out the personal information below with your transition coordinator.

Your transition coordinator will use this information in conjunction with the information above and provided by other members of your team to create a draft of your Community Transition Plan, which he or she will review with you before finalizing.

GENERAL INFORMATION

1. Do you identify with a specific race or ethnicity?
   if so, please specify: _____

2. What languages do you speak? _____

3. Do you receive a monthly check for any of the following?

   - ☐ Supplemental Security Income (SSI) $_____
   - ☐ Social Security Disability Insurance (SSDI) $_____
   - ☐ Social Security $_____
   - ☐ Veterans $_____
   - ☐ Other $_____
   - ☐ Other $_____
   - ☐ Other $_____

Please list any additional sources of your monthly income:

_____

_____

4. Please check all sources of insurance you currently receive:

- ☐ Medicaid If so, provide Medicaid number: _____
- ☐ Medicare If so, provide Medicare number:_____
- ☐ Medicare Part A
- ☐ Medicare Part B
- ☐ Private Insurance If so, provide name:_____
- ☐ Veterans
- ☐ Other: _____

LEGAL INFORMATION

1. Please check each box below that applies:

☐ I have a legal guardian

Name: _____ Phone Number: _____

☐ I have a power of attorney (medical only)

Name: _____ Phone Number: _____

☐ I have a power of attorney (general)

Name: _____ Phone Number: _____

☐ I have an emergency contact person

Name: _____ Phone Number: _____

If you **do not** have a guardian, skip to question three.
If you **do**, please provide further information below:

Type of guardianship: ( ) Full ( ) Limited

Please explain:

_____

_____

How often do you see your guardian?

_____

When was the last time you saw your guardian?

_____

What is the nature of your guardian's visits (check all that apply):

- ☐ Face to face visits
  If so, how many in the past six months? _____

- ☐ Telephone visits
  If so, how many in the past six months? _____

- ☐ Telephone, email or other contact with the facility regarding care
  If so, how many in the past six months? _____

- ☐ Telephone, e-mail or other contact with professionals regarding care
  If so, how many in the past six months? _____

2. Do advanced directives exist for your care?

- ☐ Yes. If so, who is in charge of them? _____
- ☐ No

3. Are you your own payee?

- ☐ Yes
- ☐ No

If no, would you like to be your own payee?

- ☐ Yes
- ☐ No

MEDICAL INFORMATION

1. Who is your main doctor/clinic? _____

   Phone number: _____ Email:_____

2. Where is this person/clinic located? _____

3. If available, would you prefer to receive services from this same doctor/clinic?

   - ☐ Yes
   - ☐ No, I'd like to find a different doctor/clinic

Comments:

_____

_____

4. How often do you see your main doctor/clinic?

- ☐ Weekly
- ☐ Monthly
- ☐ Other. Please explain: _____

5. Do you have other doctors besides your main doctor?

- ☐ Yes - Please provide name/specialty

  Dr._____ Specialty_____

  Dr._____ Specialty_____

- ☐ No
- ☐ I would be willing to find a new doctor/clinic closer to my home.

6. How often do you see this doctor?

- ☐ Weekly
- ☐ Monthly
- ☐ Other - Please explain _____

7. Please tell us more about your current health conditions
   (Check all that apply)

- ☐ Alzheimer's Disease
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Cerebral Palsy
- ☐ Cerebrovascular Accident (stroke)
- ☐ Congestive Heart Failure
- ☐ Deep-vein Thrombosis
- ☐ Dementia other than Alzheimer's
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema (COPD)
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hip Fracture
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

8. Have you been successful at managing your illness(es) in a community setting?

☐ Yes
☐ No

If you answered 'No', please explain:

_____

_____

9. Do you have any allergies?

☐ Yes. If so, who is in charge of them? _____
☐ No

If you answered 'Yes', please list your allergies here:

_____

_____

10. Do you currently see a counselor, psychologist or psychiatrist?

☐ Yes ___ Counselor ___ Psychologist ___ Psychiatrist
☐ No
☐ If yes, do you want to continue to see them after you move?
___Yes ___No

Comments:

_____

_____

11. Do you currently see a case manager from a mental health center?

☐ Yes
☐ No

12. Have you seen a counselor, psychologist, psychiatrist or mental health center professional in the past?

☐ Yes. If so, when? _____
☐ No

13. Are you currently taking psychotropic medication?

☐ Yes
☐ No

14. Do you currently see a substance abuse counselor?

☐ Yes
☐ No

Comments:

_____

_____

15. Have you ever had a substance abuse issue?

☐ Yes. If yes, did you receive treatment? When? _____
☐ No

Comments:

_____

_____

16. To your knowledge, do you have any of the following cognitive conditions **(Check all that apply to you)**

- ☐ Memory Loss
- ☐ Anxiety
- ☐ Behavioral Issues
- ☐ Wandering
- ☐ Depression
- ☐ Other

If you checked a box above, are you currently receiving inpatient treatment for this condition? ___ Yes ___ No Dates: _____

17. Do you receive or need occupational, physical or speech therapies?

- ☐ Yes ___Occupational ___Physical ___Speech
- ☐ No

18. Are there other medical treatments or tests you need regularly? **(Check all that apply to you)**

- ☐ No, I do not have any treatments or tests I need regularly
- ☐ Yes, I need help with the following:
  - ☐ Tests for blood sugar
  - ☐ Shots
  - ☐ Breathing treatments
  - ☐ Other: _____

Comments:

_____

_____

19. Please indicate if you have any of the following disabilities, then tell us what you feel is important for us to know about your disability.

☐ Mobility
☐ Physical
☐ Hearing
☐ Vision
☐ Multiple Disabilities

Please tell us what you think we should know about your disability:

_____

_____

20. Do you have a Medical Alert Bracelet/Tag?

☐ Yes
☐ No

Comments:

_____

_____

21. Have you completed a Five Wishes questionnaire? (instructions for your medical care)

☐ Yes
☐ No

Comments:

_____

_____

22. Will you need an emergency response system (life-line) when you transition to community living?

☐ Yes
☐ No

Comments:

_____

_____

NOTES