COMMUNITY TRANSITION SERVICES

COMMUNITY TRANSITION ASSESSMENT

CLIENT NAME _____

CLIENT INFORMATION

1. GENERAL INFORMATION

a. TRANSITION COORDINATOR LAST NAME	b. FIRST NAME	c. DATE
d. CLIENT LAST NAME	e. FIRST NAME	

f. STREET ADDRESS	g. CITY	h. ZIP

i. COUNTY	j. TELEPHONE	k.DOB	l. GENDER

m. MARITAL STATUS	n. CBMS CASE NUMBER

2. RACE/ETHNICITY (optional)

a. ☐ White
b. ☐ Black or African American
c. ☐ Asian
d. ☐ Hispanic or Latino
e. ☐ American Indian or Alaska Native
f. ☐ Native Hawaiian or other Pacific Islander
g. ☐ Not Hispanic or Latino

3. LANGUAGE

a. ☐ English	e. ☐ Spoken	i. ☐ Written
b. ☐ Spanish	f. ☐ Spoken	j. ☐ Written
c. ☐ Other:	g. ☐ Spoken	k. ☐ Written
d. ☐ Other:	h. ☐ Spoken	l. ☐ Written

4. FAMILY/FRIEND/AUTHORIZED REPRESENTATIVE SUPPORT

a. ☐ Family/friend lives close by and is supportive of transition
b. ☐ Family/friend lives close by and is not supportive of transition
c. ☐ Family/friend is available to assist in transition and continued community living
d. ☐ Family/friend is not available to assist in transition and continued community living

e. FAMILY/FRIEND NAME

f. FAMILY/FRIEND CONTACT PHONE	g. FAMILY/FRIEND CONTACT EMAIL

h. FAMILY/FRIEND STREET ADDRESS	g. CITY	h. ZIP

5. CLIENT INCOME SOURCE AND AMOUNT (fill in amounts)

a. ☐ SSI	$	h. ☐ Personal Need Allowance	$	
b. ☐ Pension	$	i. ☐ Checking Account	$	
c. ☐ Employment	$	j. ☐ Savings Account	$	
d. ☐ OAP	$	k. ☐ Trust Fund	$	
e. ☐ AND/AB	$	l. ☐ Burial Plan	$	
f. ☐ SSA	$	m. ☐ Social Security: $		☐ Application Needed
g. ☐ SSDI	$	n. ☐ Other:	$	

6. SPOUSAL FINANCIAL INFORMATION (fill in amounts)

a. ☐ SSI	$	h. ☐ Personal Need Allowance	$
b. ☐ Pension	$	i. ☐ Checking Account	$
c. ☐ Employment	$	j. ☐ Savings Account	$
d. ☐ OAP	$	k. ☐ Trust Fund	$
e. ☐ AND/AB	$	l. ☐ Burial Plan	$
f. ☐ SSA	$	m. ☐ Other:	$
g. ☐ SSDI	$	n. ☐ Other:	$

7. **INSURANCE INFORMATION** (fill in requested information)

a. ☐ CHP+
b. ☐ Long Term Care Medicaid – 300%
c. ☐ Long Term Care Medicaid – Categorical
d. ☐ Long Term Care Medicaid – Spousal 300%
e. ☐ Long Term Care Medicaid – Spousal Categorical
f. ☐ Medicaid Number:
g. ☐ Medicaid Pending
h. ☐ Medicare Part A
i. ☐ Medicare Part B
j. ☐ Medicare Part D
k. ☐ Private:
l. ☐ VA Benefits
m. ☐ Other:
1. ☐ Medicaid Application in Process; County:
2. ☐ Medicaid Application Needed
3. ☐ Medicaid Application Mailed; Date:

8. **LEGAL INFORMATION**

a. LEGAL GUARDIAN NAME	b. GUARDIAN'S PHONE
c. POWER OF ATTORNEY	d. MEDICAL POWER OF ATTORNEY
e. ADVANCE DIRECTIVES	
f. EMERGENCY CONTACT NAME	g. EMERGENCY CONTACT PHONE
h. PERSON IS OWN PAYEE	i. PERSON DESIRES TO BE OWN PAYEE

9. **CLIENT/GUARDIAN RELATIONSHIP INFORMATION – Client Report**

a. Type of guardianship

☐ Full
Comments:

☐ Limited
Please explain:

b. How often does the client see the guardian?	c. When was the last time the client saw the guardian?
d. What is the nature of the guardian's visits?	
☐ Face to face Visits	If so, how many in past 6 months:
☐ Telephone contacts	If so, how many in past 6 months:
☐ Email or other contact	If so, how many in past 6 months:

10. **GUARDIANSHIP – Guardian Report**

Is guardian a resident of the State of Colorado Yes ☐ No ☐ City _____

Is guardian able to participate in discharge planning Yes ☐ No ☐

Is guardian available to participate in a service planning meeting at least annually Yes ☐ No ☐

Is guardian able to perform all guardian responsibilities as legally required Yes ☐ No ☐

Please describe the level of contact the guardian has had with this consumer over the past six months:

☐ Face to face visits — If so, how many:

☐ Telephone contacts — If so, how many:

☐ Telephone, email or other contact with the facility regarding care — If so, how many:

☐ Telephone, e-mail or other contact with other professionals regarding care — If so, how many:

☐ Copies of guardianship papers obtained

11. **MEDICAL CONDITION**

a. PHYSICIAN'S NAME		b. PHONE
c. STREET ADDRESS	d. CITY	e. ZIP
f. UNDER PHYSICIAN'S CARE?	☐ Yes ☐ No	

12. ALLERGIES

a. ☐ Penicillin c. ☐ Insulin e. ☐ Anti-convulsants
b. ☐ Sulfa d. ☐ Iodine f. ☐ Other

13. ULTC 100.2 AND IADL ASSESSMENT

a. Date Completed

b. Comments:

14. SINGLE ENTRY POINT AGENCY

a. CASE MANAGER'S NAME	b. CASE MANAGER'S PHONE
c. CASE MANAGEMENT AGENCY	
d. PHYSICIAN'S NAME	e. PHYSICIAN'S PHONE

15. NURSING FACILITY

a. FACILITY NAME		b. PHONE
c. STREET ADDRESS	d. CITY	e. ZIP
f. CONTACT NAME OR TITLE		g. CONTACT PHONE
h. DATE OF CURRENT ADMISSION		
i. PREVIOUS NURSING FACILITY ADMISSION(S):		j. DATE(S)

16. PAYEE SHIP

a. If you require a payee, do you have suggestions about who could be your payee?

b. How did your payee ship change?

c. Are you interested in learning the skills to be your own payee?

17. PAYEE SHIP NEEDS

a. ☐ Develop plan to transition payee ship d. ☐ Change payee ship prior to discharge
b. ☐ Schedule meeting at Social Security e. ☐ Establish plan for client to receive check
c. ☐ Develop plan for client to learn the skills to become own payee

18. CONSULTATIONS IN SUPPORT OF TRANSITION

a. ☐ Physician is supportive ☐ No Comments:
b. ☐ Nursing facility is supportive ☐ No Comments:
c. ☐ Mental health provider is supportive ☐ No Comments:
d. ☐ HCPF CTS Administrator Consultation (if applicable)

19. TRANSITION OPTIONS TEAM MEMBERS

Name	Agency	Phone	E-mail

BEHAVIORAL HEALTH

20. MENTAL HEALTH

a. ☐ No Problem
b. ☐ Receiving mental health treatment
c. ☐ Past mental health treatment
d. ☐ Has managed mental illness **successfully** in the past

e. ☐ Hospitalization:
   1. Dates of Hospitalization(s):
f. ☐ Psychoactive Medication:
   1. Type(s):

Explanation of **successful or unsuccessful** management of mental illness:

21. SUBSTANCE ABUSE

a. ☐ No Problem
b. ☐ Current Abuse
c. ☐ Past Abuse
d. ☐ Has managed a substance abuse problem in the past

e. ☐ Risk of Relapse
f. ☐ Inpatient Treatment Dates:
g. ☐ Drug(s) of choice:

Explanation of **successful or unsuccessful** management of mental illness:

22. COGNITIVE OR BEHAVIOR*

* If resident is unable to answer, get information from another source, but identify the source:

a. ☐ Memory Loss issue
b. ☐ Anxiety issue
c. ☐ Inpatient Treatment:
   1. Dates of treatment(s):

d. ☐ Behavioral Concerns
   1. Explain:
e. ☐ Wandering problem
   1. Explain:

23. BEHAVIORAL REASON FOR ENTERING CURRENT NURSING FACILITY

a. ☐ Treatment for **Mental Illness** was a **reason for entering** Current Facility
   1. ☐ Condition has improved since admission

b. ☐ Treatment for **Cognitive or Behavioral Disorder** was a **reason for entering** Current Facility
   1. ☐ Condition has improved since admission

24. CURRENT NURSING FACILITY THERAPIES FOR BEHAVIORAL HEALTH – Check all that apply

a. ☐ Psychological	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
b. ☐ Cognitive	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
c. ☐ Medication Management	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
d. ☐ Social Worker or Therapist	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
e. ☐ Secure Unit	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
f. ☐ Other	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:

25. BEHAVIORAL HEALTH – ADDITIONAL INFORMATION – Check all that apply

a. ☐ Emergency Services (for Behavioral health reasons) within the last 6 months?	1. Number of contacts: 2. Reason for contacts:
b. ☐ Behavioral Health Issues that negatively impact ability to Maintain Residence in the Community:	1. ☐ Frequency of illness or hospitalization 2. ☐ Difficulty of managing symptoms 3. ☐ Non- compliance with medication instructions 4. ☐ Other: Details:
c. ☐ Has been unable to return home from the hospital or rehab facility for the following:	1. ☐ Inability to take medications as prescribed 2. ☐ Multiple failed attempts to live in the community 3. ☐ Lack of behavioral health services 4. ☐ Family does not support living in the community 5. ☐ Negative impact of substance abuse 6. ☐ Mental health provider does not support living in the community 7. ☐ Other:

26. COGNITIVE OR MEMORY NEEDS

a. ☐ Planner	c. ☐ Intensive home medication monitoring	e. ☐ Peer Support	g. ☐ AA
b. ☐ Medication box	d. ☐ Assistance to get provider appointments	f. ☐ Programmable watch	h. ☐ Other

MEDICAL

27. MEDICAL CONDITION

a. ☐ No Medical Condition b. ☐ Past treatment for medical condition

28. MEDICAL REASON FOR ENTERING CURRENT NURSING FACILITY

a. ☐ Treatment for **Medical Condition** was a **reason for entering** Current Facility
   1. ☐ Medical condition has improved since admission

29. MEDICAL – ADDITIONAL INFORMATION – Check all that apply

b. ☐ Medical Issues that negatively impact ability to Maintain Residence in the Community:	1. ☐ Lack of medical, nursing, or therapy services 2. ☐ Change of health conditions 3. ☐ Lack of or no record of emergency contact 4. ☐ Frequency of illness or hospitalizion 5. ☐ Difficulty of managing symptoms 6. ☐ Non- compliance with medication instructions 7. ☐ Specific of medical condition Details:
c. ☐ Has been unable to return home from the hospital or rehab facility for the following:	1. ☐ Lack of medical, nursing, or therapy services Describe: 2. ☐ Cost of medical, nursing, or therapy services 3. ☐ Frequency of illness or hospitalization 4. ☐ Other:
☐ Emergency Services (for Medical reasons) within the last 6 months?	1. Number of contacts: 5. Reason for contacts:

30. COGNITIVE OR MEMORY NEEDS

a. ☐ Physician	d. ☐ Medical alert bracelet	g. ☐ Incontinence supplies
b. ☐ Home health	e. ☐ Medical alert tag	h. ☐ Oxygen
c. ☐ Disposable supplies	f. ☐ Diabetic supplies	i. ☐ Other:

31. CURRENT NURSING FACILITY THERAPIES FOR MEDICAL ISSUES – Check all that apply

a. ☐ RN or CNA	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:

b. ☐ Repertory	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
c. ☐ Chemotherapy	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
d. ☐ Radiation	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
e. ☐ Dialysis	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
f. ☐ Physician	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
g. ☐ Medication Management	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:

32. MEDICAL – ADDITIONAL INFORMATION – Check all that apply

a. ☐ Emergency Services (for Medical reasons) within the last 6 months?	2. Number of contacts: 3. Reason for contacts:
b. ☐ Medical Issues that negatively impact ability to Maintain Residence in the Community:	8. ☐ Lack of medical, nursing, or therapy services 9. ☐ Change of health conditions 10. ☐ Lack of or no record of emergency contact 11. ☐ Frequency of illness or hospitalizion 12. ☐ Difficulty of managing symptoms 13. ☐ Non- compliance with medication instructions 14. ☐ Specific of medical condition Details:
c. ☐ Has been unable to return home from the hospital or rehab facility for the following:	6. ☐ Lack of medical, nursing, or therapy services Describe: 7. ☐ Cost of medical, nursing, or therapy services 8. ☐ Frequency of illness or hospitalization 9. ☐ Other:

PHYSICAL ACCESSIBILITY

33. PHYSICAL DISABILITY

a. ☐ No Problem	
b. ☐ Mobility	Describe:
c. ☐ Physical	Describe:
d. ☐ Hearing	Describe:
e. ☐ Vision	Describe:
f. ☐ Multiple Disability	Describe:
g. ☐ Specific Disability	Describe:

34. PHYSICAL – ADDITIONAL INFORMATION – Check all that apply

a. ☐ Has been unable to return home from the hospital or rehab facility for the following personal care issues:	1. ☐ Inability of family/friends to provide personal care 2. ☐ Shortage of good attendants 3. ☐ Cost of paying attendants 4. ☐ Lack of medical, nursing, or therapy services Describe: 5. ☐ Need for home modifications 6. ☐ Need for adaptive aids or mobility devices 7. ☐ Other:

b. ☐ Personal Care Assistance Issues that negatively impact ability to Maintain Residence in the Community:	1. ☐ Need for Services to help maintain residence 2. ☐ Concern for safety by family or friends 3. ☐ Need for home modifications 4. ☐ Need for adaptive aids or mobility devices 5. ☐ Other:

35. Home Modification

a. ☐ Widened doors	f. ☐ Bathroom handrails	k. ☐ Environmental control system
b. ☐ No Step entrance	g. ☐ Roll-In shower	l. ☐ Transfer equipment
c. ☐ No stairs	h. ☐ Automatic door opener	m. ☐ Lifting chair
d. ☐ Entrance ramp	i. ☐ Wheelchair access kitchen	n. ☐ Home Modifications
e. ☐ First floor apartment	j. ☐ Curb cut	o. ☐ Other:

36. PERSONAL CARE ASSISTANCE REQUIREMENTS

a. ☐ Bed or wheelchair transfer	e. ☐ Cooking or eating	i. ☐ Dressing change
b. ☐ Walking or using wheelchair, cane, or other mobility device	f. ☐ Medication administration	j. ☐ Bathing, personal hygiene
c. ☐ Grocery shopping	g. ☐ Medication set up	k. ☐ Toilet
d. ☐ House cleaning	h. ☐ Medication monitoring	l. ☐ Other:

37. ASSISTIVE TECHNOLOGY NEEDS

a. ☐ Mobility appliances	j. ☐ Manual wheelchair	s. ☐ Power wheelchair
b. ☐ Shower chair	k. ☐ Shower bench	t. ☐ Brace(s) or Prosthetics
c. ☐ Cane, walker, crutch	l. ☐ Life line	u. ☐ Computer
d. ☐ Transfer equipment	m. ☐ Lifting chair	v. ☐ Regular bed
e. ☐ Fully-automatic bed	n. ☐ Semi-automatic bed	w. ☐ Therapeutic mattress
f. ☐ I.V. supplies	o. ☐ Feeding tube	x. ☐ Modified utensils
g. ☐ Glasses	p. ☐ Contact lens	y. ☐ Hearing aid(s)
h. ☐ TTY	q. ☐ Modified phone	z. ☐ Sound doorbell
i. ☐ Other:	r. ☐ Other:	aa ☐ Other:

38. CURRENT NURSING FACILITY THERAPIES FOR PHYSICAL Disabilities – Check all that apply

a. ☐ Speech	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
b. ☐ Occupational Therapy	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:
c. ☐ Physical	1. ☐ Ongoing; How many sessions: ☐ per day ☐ per week ☐ per month 2. ☐ Time Limited; How many more sessions: 3. ☐ Additional Treatment is Necessary Before Transition; Describe:

HOUSE & HOUSEHOLD SET-UP

39. PREFERENCE FOR LIVING ARRANGEMENT

a. ☐ Alone	e. ☐ With unidentified roommate	i. ☐ Return to previous residence
b. ☐ With family	f. ☐ Assisted living	j. ☐ Desired location (county, city)
c. ☐ With friend(s)	g. ☐ Host Home	k. County:
d. ☐ With identified roommate	h. ☐ RSS (DD)	l. City:

40. HOUSEHOLD – ADDITIONAL INFORMATION – Check all that apply

a. ☐ Housing Issues that negatively impact ability to Maintain Residence in the Community:	1. ☐ Need for Services to help maintain residence 2. ☐ Cost of rent or other services 3. ☐ Need for home modifications 4. ☐ Not complying with rental rules 5. ☐ Difficulty with room mate 6. ☐ Other:

41. FINANCES, ANTICIPATED RELOCATION EXPENSES

a. HUD Section 8/Housing Voucher	1. ☐ Has	2. ☐ Needs
b. First month's rent	1. ☐ Has	2. ☐ Needs
c. Utility payments	1. ☐ Has	2. ☐ Needs
d. Rent deposit	1. ☐ Has	2. ☐ Needs
e. Rental Assistance	1. ☐ Has	2. ☐ Needs

42. HOUSING

a. ☐ Previous Residence	b. ☐ Independent Apartment	c. ☐ Assisted Living	d. ☐ Alternative Care Facility
1. ☐ Roommate	1. ☐ Roommate	1. ☐ Roommate	1. ☐ Roommate
2. ☐ Section 8	2. ☐ Section 8	2. ☐ Section 8	2. ☐ Section 8
3. Utility Deposit:	3. Utility Deposit:	3. Utility Deposit:	3. Utility Deposit:
4. Rent:	4. Rent:	4. Rent:	4. Rent:
5. Move-in Date:	5. Move-in Date:	5. Move-in Date:	5. Move-in Date:
6. Address:	6. Address:	6. Address:	6. Address:
e. ☐ Residential Group Home	f. ☐ Private With Family	g. ☐ Host Home	h. ☐ Other:
1. ☐ Roommate	1. ☐ Roommate	1. ☐ Roommate	1. ☐ Roommate
2. ☐ Section 8	2. ☐ Section 8	2. ☐ Section 8	2. ☐ Section 8
3. Utility Deposit:	3. Utility Deposit:	3. Utility Deposit:	3. Utility Deposit:
4. Rent:	4. Rent:	4. Rent:	4. Rent:
5. Move-in Date:	5. Move-in Date:	5. Move-in Date:	5. Move-in Date:
6. Address:	6. Address:	6. Address:	6. Address:

43. HOUSEHOLD – SET-UP ITEMS - Check all that apply

a. ☐ Furniture	d. ☐ Food	g. ☐ File box
b. ☐ Bed	e. ☐ House ware items	h. ☐ Other:
c. ☐ Linens	f. ☐ Toiletries	i. ☐ Other:

TRANSPORTATION

44. TRANSPORTATION REQUIREMENTS OR PREFERENCES:

a. ☐ Fixed route bus	d. ☐ Paratransit/demand response eligibility	g. ☐ Taxi
b. ☐ Personal vehicle	e. ☐ Non-Medical transportation to Day Program	h. ☐ Medical transportation
c. ☐ Family or Friends	f. ☐ Door-to-Door Attendant	i. ☐ Other:

45. TRANSPORTATION ASSISTANCE NEEDED

a. ☐ Travel training	e. ☐ Orientation and mobility instruction	h. ☐ Escort
b. ☐ Para transit scheduling	f. ☐ Non-medical transportation	i. ☐ Medical transportation
c. ☐ Vehicle transfer	g. ☐ Training for fixed-route bus	j. ☐ Other:
d. ☐ Eligibility establishment for paratransit/demand response use		

46. TRANSPORTATION - ADDITIONAL INFORMATION – Check all that apply

a. ☐ Transportation Issues that negatively impact ability to **Maintain Residence** in the Community:	1. ☐ Difficulty in Maintaining Residence in the Community 2. ☐ Need for adequate transportation 3. ☐ Other:
b. ☐ Has been **unable to return home** from the hospital or rehab facility for the following Transportation issues:	1. ☐ Difficulty in Maintaining Residence in the Community 2. ☐ Need for adequate transportation 3. ☐ Other:

INDEPENDENT LIVING

47. INDEPENDENT LIVING ASSISTANCE REQUIREMENT

a. ☐ Hygiene Maintenance	d. ☐ Laundry	g. ☐ Other:
b. ☐ Meal Preparation	e. ☐ Travel Training	g. ☐ Other:
c. ☐ Housework	f. ☐ Home Maintenance	g. ☐ Other:

48. INDEPENDENT LIVING – ADDITIONAL INFORMATION– Check all that apply

a. ☐ Independent Living Issues that negatively impact ability to Maintain Residence in the Community:	1. ☐ Need for Services to help maintain residence 2. ☐ Need for Services to help with money management or decision-making 3. ☐ Concern for safety by family or friends 4. ☐ Other:

EMPLOYMENT

49. EMPLOYMENT INFORMATION

a. ☐ Retired	e. ☐ Interested in getting or changing job	h. ☐ Employed fulltime
b. ☐ Not employed	f. ☐ Not interested in getting or changing job	i. ☐ Works at home
c. ☐ Attends sheltered workshop	g. ☐ Attends pre-vocational day activity or work activity program	
d. ☐ Interested in attending pre-vocational day activity or work activity program		j. ☐ Other:

50. NEED FOR ASSISTANCE TO WORK

a. ☐ Independent (with devices, if used)	c. ☐ Needs help every day (but does not need continuous presence of another person)	e. ☐ Vocational Rehabilitation
b. ☐ Needs help weekly or less (for example, if problems arise)	d. ☐ Needs continual presence of another person	f. ☐ Other:

FINANCES

51. ANTICIPATED RELOCATION EXPENSES

a. ☐ Moving costs; Estimated Cost: $	c. ☐ Utility deposit: Estimated Cost: $
b. ☐ Rent deposit; Estimated Cost: $	d. ☐ Other: Estimated Cost: $

52. FINANCES, UNPAID OR ONGOING DEBTS

a. ☐ Landlord	$__	d. ☐ Housing authority	$__	g. ☐ Utility bills	$__
b. ☐ Child support	$__	e. ☐ Mortgage	$__	h. ☐ Credit cards	$__
c. ☐ Other	$__	f. ☐ Other	$__	i. ☐ Other	$__

53. FINANCES - ADDITIONAL INFORMATION – Check all that apply

a. ☐ Financial Issues that negatively impact ability to Maintain Residence in the Community:	4. ☐ Cost of paying attendants; Estimated Cost: $ 5. ☐ Cost of rent or other bills; Estimated Cost: $ 6. ☐ Unable to budget 7. ☐ Other:
b. ☐ Has been unable to return home from the hospital or rehab facility for the following Financial issues:	4. ☐ Cost of paying attendants 5. ☐ Cost of medical, nursing, or therapy services 6. ☐ Cost of rent or other bills 7. ☐ Past unpaid bills 8. ☐ Other: