Targeted Case Management - Transition Coordination (TCM-TC)

COMMUNITY NEEDS & PREFERENCES ASSESSMENT

MEMBER NAME ____

MEMBER INFORMATION

1. GENERAL INFORMATION

a. TRANSITION COORDINATOR LAST NAME		b. FIRST NAME	c. DATE
d. MEMBER LAST NAME		e. FIRST NAME	
f. STREET ADDRESS	g. CITY		h. ZIP
i. COUNTY	j. TELEPHONE	k.DOB	l. GENDER
m. MARITAL STATUS			

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	i. CITY	j. ZIP

5. MEMBER INCOME SOURCE AND AMOUNT (fill in amounts) SNF to provide 5615 income award letters

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. ☐ Personal Needs Accounts	$

6. SPOUSAL FINANCIAL INFORMATION (fill in amounts) SNF to provide 5615 income award letters

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) SNF to provide common working file

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 SNF to provide legal documents

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

9. MEMBER/GUARDIAN RELATIONSHIP INFORMATION – MEMBER Report

a. Type of guardianship

☐ Full
Comments:

☐ Limited
Please explain:

b. How often does the MEMBER see the guardian?	c. When was the last time the MEMBER 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 SNF to provide 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 ☐

11. MEDICAL PROVIDER (Current)

a. PHYSICIAN'S NAME	b. PHONE	
c. STREET ADDRESS	d. CITY	e. ZIP
g. PSYCHIATRIST'S NAME	h. PHONE	
i. STREET ADDRESS	j. CITY	k. ZIP

12. 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)

13. PAYEESHIP SNF to provide relevant documents

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

b. How did your payeeship change?

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

14. PAYEESHIP NEEDS

a. ☐ Develop plan to transition payeeship

b. ☐ Schedule meeting at Social Security

c. ☐ Develop plan for MEMBER to learn the skills to become own payee

d. ☐ Change payeeship prior to discharge

e. ☐ Establish plan for MEMBER to receive check

15. CONSULTATIONS IN SUPPORT OF TRANSITION

a. ☐ Facility physician is supportive Comments:

b. ☐ Community physician is supportive Comments

c. ☐ Nursing facility is supportive Comments:

d. ☐ Mental health provider is supportive Comments:

e. ☐ HCPF CTS Administrator Consultation (if applicable) Comments

16. TRANSITION OPTIONS TEAM MEMBERS

Name	Agency	Phone	E-mail

17. BEHAVIORAL 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:

18. 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 substance abuse:

19. COGNITIVE OR BEHAVIOR*

* If resident is unable to answer, obtain 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:

20. BEHAVIORAL REASON FOR ENTERING CURRENT NURSING FACILITY

SNF to provide relevant documents

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

21. 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 2. ☐ Time Limited; Targeted Date to Move to Non-Secure Unit 3. ☐ Additional Treatment is Necessary Before Move to Non-Secure Unit; 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:

22. 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 move to an independent setting from the nursing facility or ICF-I/DD 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:

23. 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

24. MEDICAL CONDITION

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

25. ALLERGIES

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

26. CURRENT HEALTH CONDITIONS

a. ☐ Alzheimer's Disease	g. ☐ Congestive Heart Failure	m. ☐ Glaucoma
b. ☐ Anxiety Disorder	h. ☐ Deep-vein Thrombosis	n. ☐ Heart Disease
c. ☐ Arthritis	i. ☐ Dementia other than Alzheimer's	o. ☐ Hip Fracture
d. ☐ Asthma	j. ☐ Depression	p. ☐ Other:
e. ☐ Cerebral Palsy	k. ☐ Diabetes	q. ☐ Other:
f. ☐ Cerebrovascular Accident (stroke)	l. ☐ Emphysema (COPD)	r. ☐ Other:

27. 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

28. MEDICAL – ADDITIONAL INFORMATION – Check all that apply	
a. ☐ 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 hospitalization 5. ☐ Difficulty of managing symptoms 6. ☐ Non- compliance with medication instructions 7. ☐ Specific of medical condition Details:
b. ☐ Has been unable to move to an independent setting from the nursing facility or ICF-I/DD 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: 2. Reason for contacts:

29. MEDICAL 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:

30.HOME HEALTH CARE NEEDS	
a. ☐ Skilled care	☐ Other
b. ☐ Medication Administration	☐ Other
c. ☐ Medication Managment	☐ 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. ☐ Respiratory	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:

PHYSICAL ACCESSIBILITY

32. 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:

33. PHYSICAL – ADDITIONAL INFORMATION – Check all that apply

a. ☐ Has been unable to move to an independent setting from the nursing facility of ICF-I/DD 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. ☐ Other:

34. Home Modification

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

35. PERSONAL CARE ASSISTANCE REQUIREMENTS

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

36.DURABLE MEDICAL EQUIPMENT AND 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. ☐ Hoyer lift:	r. ☐ Transfer equipment:	Aa. ☐ Nebulizer
Bb. ☐ Oxygen	Cc. ☐ Medication reminder	Dd. ☐ Other

37. 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

38. 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:

39. 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 roommate 6. ☐ Other:

40. 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

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

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

TRANSPORTATION

42. 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:

43. TRANSPORTATION ASSISTANCE NEEDED

a. ☐ Travel training	e. ☐ Orientation and mobility instruction	h. ☐ Escort
b. ☐ Paratransit 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		

44. 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 move to an independent **setting** from the nursing facility or ICF-I/DD for the following transportation issues:	1. ☐ Need for adequate transportation 2. ☐ Other: 3. ☐ Other:

LIFE SKILLS TRAINING

45. LIFE SKILLS TRAINING

a. ☐ Assistance to avoid risk of substance abuse relapse	j. ☐ Adjusting to living alone	s. ☐ House cleaning
b. ☐ Organizational skills	k. ☐ Ordering/picking up prescriptions	t. ☐ Personal care/hygiene
c. ☐ Accessing resources/application assistance SSI/SSDI, food stamps LEAP	l. ☐ Managing behavioral health symptoms	u. ☐ Grocery shopping/meal preparation
d. ☐ Paying bills	m. ☐ Household management and maintenance	v. ☐ Family integration issues
e. ☐ Transfer payee-ship prior to discharge	n. ☐ Keeping appointments	w. ☐ Establish and follow emergency plan
f. ☐ Travel training	o. ☐ Budgeting/bank accounts	x. ☐ Neighborhood and community integration
g. ☐ Eligibility establishment for medical transportation	p. ☐ Social Security application process	y. ☐ Building social support network including faith-based community
h. ☐ Laundry training	q. ☐ Paratransit scheduling	z. ☐ Establish plan to receive social security check
i. ☐ Medication management/compliance	r. ☐ Vehicle transfer	Aa ☐ Develop and implement activity/social preference goals

Bb. Other:

46. LIFE SKILLS TRAINING – 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

47. 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:

48. 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

49. 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	$__

50. FINANCES - ADDITIONAL INFORMATION – Check all that apply

a. ☐ Financial Issues that negatively impact ability to maintain residence in the community:	1☐ Cost of paying attendants; Estimated Cost: $ 2☐ Cost of rent or other bills; Estimated Cost: $ 3☐ Unable to budget 4☐ Other:
b. ☐ Has been unable to move to an independent setting from the nursing facility or ICF-I.DD facility for the following financial issues:	5☐ Cost of paying attendants 6☐ Cost of medical, nursing, or therapy services 7☐ Cost of rent or other bills 8☐ Past unpaid bills 9☐ Other: