

**New Jersey Department of Human Services
Division of Aging Services
TRANSITION PLAN**

Consumer Name	Date of NF Admission
Dates of Previous NF Admissions and Discharges	

Consumer's Goals:

1. _____
2. _____
3. _____
4. _____

Cultural Concepts/Personal Preferences to be Considered:

1. _____
2. _____
3. _____
4. _____

Desired Outcomes – Maintenance, Independence, Rehabilitation, Prevention or Other:

1. _____
2. _____
3. _____

Consumer Strengths/Desires/Responsibilities to Achieve Goals:

1. _____
2. _____
3. _____

Consumer's Support System to Achieve Goals:

1. _____
2. _____
3. _____
4. _____

TRANSITION PLAN, Continued

Consumer Name _____

Services and Supports Needed for Transition:

Service Needed	Frequency	Number of Units	Cost per Unit	Total Cost

Justification for Waiver Service Costs that exceed \$2,841 per month:

Consumer Risk Factors:

Factors that, if not addressed, might pose a high threat to an individual's health and welfare. These include: (a) health risk (medical conditions that require continuing care and treatment); (b) behavioral risk (behaviors or conditions that might cause harm to the person or others); and, (c) personal safety risk (e.g., safe evacuation).

1. _____
2. _____
3. _____
4. _____

Backup Plan(s) to Address Risk Factors:

Provision for alternative arrangements for the delivery of services that are critical to participant well being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them.

1. _____
2. _____
3. _____
4. _____

Transition Team Members, Phone Number and Responsibilities:

Name	Phone number	Responsibilities

TRANSITION PLAN, Continued

Consumer Name

Consumer Choices

- | | Yes | No | N/A |
|--|--------------------------|--------------------------|--------------------------|
| 1. I have been advised and understand that I may choose to remain in the nursing facility or move to a community setting to receive home and community-based services..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I voluntarily choose to return to the community to receive home and community-based services..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I have been advised about the Global Options (GO) Program and services..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I voluntarily agree to participate in the GO Program..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I have been advised of the potential risk factors identified in this Transition Plan if I leave the nursing facility to return to a community setting with services through the GO Program..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. I understand and accept the potential risk factors if I leave the nursing facility to return to a community setting..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. I was a member of the Transition Team that planned my discharge from the Nursing facility to the community..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. I helped develop this Transition Plan and the Plan of Care..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. I had the freedom to choose my services under the GO Program..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. I had the freedom to choose the providers of my services based on available providers. I am aware that I may not receive the providers I have chosen..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. I agree with this Transition Plan and the Plan of Care..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. I was advised that the amount, frequency, and continuation of services depend upon the availability of state and federal funds..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. I am aware that I may have a cost share for Assisted Living/Adult Family Care..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Anticipated Date of Discharge

Consumer	Date
Witness	Date
Witness	Date
Witness	Date

Actual Date of Discharge	Destination
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