KENTUCKY TRANSITIONS
TRANSITION PLAN

□ SCLT
□ HCBT
□ ABIT

1. MEMBER NAME:_____

2. SEX: □ MALE □ FEMALE

3. MAID NUMBER: _____ 4. DOB_____

5. FACILITY:_____

   ADDRESS:_____

   PHONE:_____

6. GUARDIAN NAME_____ RELATIONSHIP:_____

   ADDRESS:_____PHONE:_____

7. POWER OF ATTORNEY_____RELATIONSHIP:_____

   ADDRESS:_____PHONE:_____

8. REPRESENTATIVE NAME (CDO)_____RELATIONSHIP:_____

   ADDRESS:_____PHONE:_____

9. LEVEL OF CARE (LOC) PA NUMBER:_____

10. PA DATES: FROM_____TO_____

11. DIAGNOSES:_____

    _____

MEMBER NAME: _____MAID NUMBER_____

IDENTIFICATION OF TRANSITION NEEDS/GOALS/SERVICES/MONTHLY COST

NEEDS	GOALS	SERVICE	PROVIDER	MONTHLY COST

COMMENTS:_____

_____

_____

_____

_____

MEMBER NAME: _____MAID NUMBER_____

IDENTIFICATION OF CLINICAL NEEDS/GOALS/SERVICES/MONTHLY COST

NEEDS	GOALS	SERVICE	PROVIDER	MONTHLY COST

COMMENTS:_____

_____

_____

_____

_____

MEMBER NAME: _____MAID NUMBER_____

IDENTIFICATION OF SOCIAL NEEDS/GOALS/SERVICES/MONTLY COST

NEEDS	GOALS	SERVICE	PROVIDER	MONTHLY COST

COMMENTS:_____

_____

_____

_____

_____

MEMBER NAME: _____MAID NUMBER_____

IDENTIFICATION OF CDO NEEDS/GOALS/SERVICES/MONTHLY COST
(IF CDO OPTION IS CHOSEN)

NEEDS	GOALS	INTERVENTIONS	SERVICES	PROVIDER

COMMENTS:_____

_____

_____

_____

_____

MEMBER NAME: _____MAID NUMBER_____

EMERGENCY BACK-UP PLAN (INCLUDE DETAILED BACK-UP PLAN FOR EACH SERVICE LISTED)

MEMBER NAME: _____MAID NUMBER_____

CLINICAL/SOCIAL SUMMARY:

HOUSING SUMMARY:

SUMMARY OF PRE-TRANSITION/TRANSITION SERVICE NEEDS:

DATE OF TRANSITION:_____

PLAN FOR TRANSTION INTO COMMUNITY RESIDENCE:

SIGNATURES:

TRANSITION TEAM:_____

_____ DATE:_____

PARTICIPANT:_____

_____ DATE:_____

GUARDIAN:_____

_____ DATE:_____

POA:_____

_____ DATE:_____

OTHER_____:_____

_____ DATE:_____

CDO REPRESENTATIVE (IF CDO CHOSEN:_____

_____ DATE:_____