MONEY FOLLOWS THE PERSON (MFP) REFERRAL PACKET CHECKLIST
NURSING FACILITY TRANSITIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING SERVICES - MFP
DN 1022 (9-2022)

Check off the following steps when completed:

The following documents can be found at www.nd.gov/dhs/info/pubs/mfp/overview.html

Review and provide a copy of the following information:	
☐	MFP Brochure
☐	MFP Fact Sheet
☐	MFP Role Matrix (DN 894)
☐	Independent Living Philosophy & Person-Centered Planning (DN 1368)
☐	Guardianship Expectations Document- If Needed (DN 1369)
Information/action needed during first visits:	
☐	Review Eligibility Criteria for MFP
☐	Review grievance/rights process for CIL and MFP
☐	Complete Interview Portion of SFN 584 (If we do not have a SFN 892)
☐	Complete MFP Informed Consent for Participation (DN 881)
☐	Release of Information obtained for Nursing Facility, MFP, HCBS, Housing Facilitator, etc. (Use CIL release)
☐	Obtain Nursing Facility Care plan and Medication Administration Record (optional)

MONEY FOLLOWS THE PERSON

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Money Follows the Person Transition Team Process

Qualified individuals requesting assistance with transition from an institutional setting will be assigned a transition team. The Transition Team will include the *MFP Transition Coordinator*, the *Home and Community Based Services (HCBS) Case Manager*, and a *Housing Facilitator*.

Together the Transition Team will jointly respond to each Money Follows the Person referral. The Transition Coordinator is responsible to take the lead role in coordinating the transition planning process with the individual/family and all team members. **This lead role will include assuring ongoing communication and coordination with everyone involved throughout the process from the day of referral until the end of the individual's MFP eligibility.**

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MFP and ADRL Transition Services Referral Sources

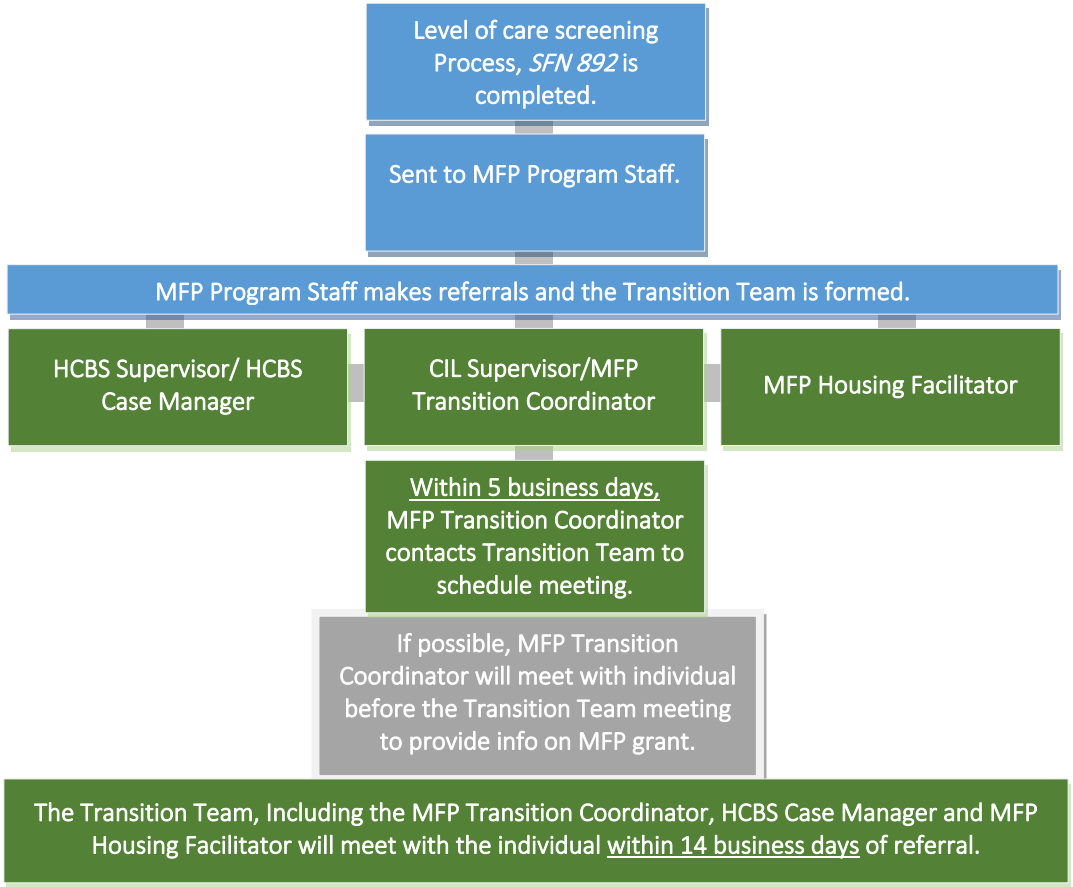
Referrals:

MFP referrals will be given to the Transition Team two ways:

- 1. Long Term Services and Supports Options Counseling Referral (SFN 892) or (SFN 1265/1267)
- 2. Skilled Care Referral for Long-term Services and Supports from a Nursing Facility (SFN 584)

1. Long Term Services and Supports Options Counseling Referral:

- **Level of Care Screening Process,** *SFN 892* Informed Choice is completed and sent to MFP Program staff.
- The MFP Program staff will email the referral to the Aging Services Program Administrator (to assign HCBS case manager), the MFP Housing Facilitator, and the Center for Independent Living to begin the MFP Grant Transition Process.
- The MFP Transition Coordinator will contact the HCBS Case Manager and the Housing Facilitator, within 5 business days of the receipt of the referral and arrange for a meeting with the individual at the Nursing Facility.
- If possible, the MFP Transition Coordinator will meet with the individual prior to the transition team meeting to explain the MFP program and process.
- The Transition Team meeting with the MFP Transition Coordinator, HCBS Case Manager and Housing Facilitator must be completed within 14 business days of the referral.



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2. *SFN 584*: Skilled Care Referral for Long-term Services and Supports Required Referral from a Nursing Facility:

Nursing Facilities are required to ask each person at least annually "If they want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community?" If the individual says "yes" they want to talk with someone, the nursing home will complete the *SFN 584* requesting a visit with the agency designated by the North Dakota Department of Human Services.

Nursing Home Assessment Question:

Q0500. Return to Community	
Enter Code ☐	**B. Ask the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**

MFP is designated to complete these required visits for all individuals either receiving Medicaid or may be eligible for state funded home and community-based services based on their income. This is a visit to provide information on community/MFP services.

These referral visits will be for all for individuals either receiving Medicaid or that are Specialized Payment for the Elderly and Disabled (SPED) eligible based on income.
These visits will be considered *MFP Outreach Visits* to determine interest in transition and MFP Services.

Process and Timeframe:
The MFP Transition Coordinator will:

- Contact the nursing facility within 5 business days of receipt of the referral to schedule a visit with the individual.
- Complete the visit within 10 business days of the receipt of the referral (in person or virtual).
- Review the individuals' goals, support needs, and provide information about MFP grant or other services that might support their move home.
- Complete the *Meeting Information* section of the *SFN 584* document starting on page 3.
- Provide a copy to the individual and nursing facility staff in person or by email within 3 business days.
- Upload a completed copy of the *SFN 584* in the Transition Documents section in Therap.
- Scomm MFP Program Staff to notify them the SFN 584 has been uploaded.
- If Individual does not want to transition (does not sign consent DN 881), complete a termination case note in Therap.

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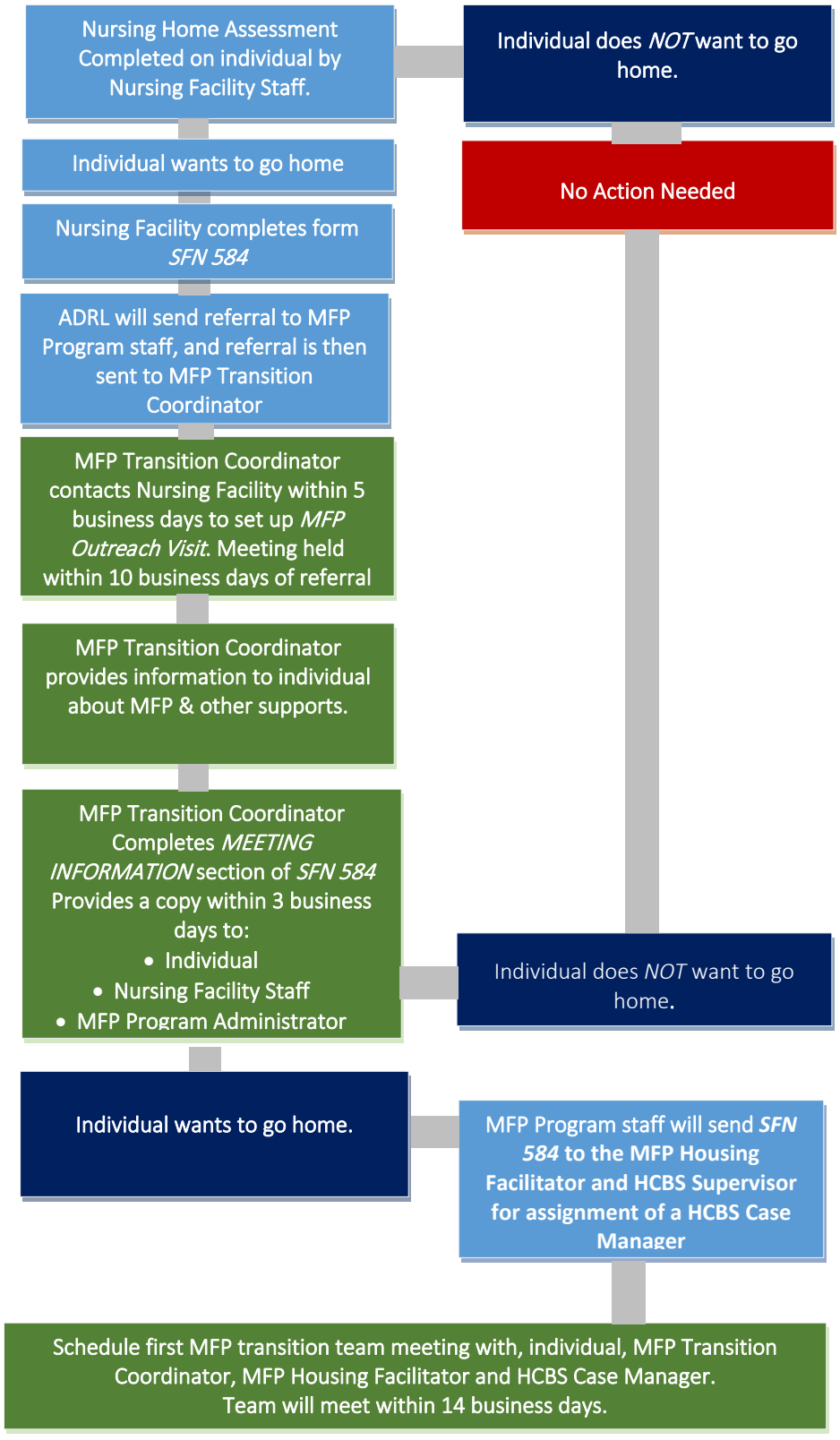

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MFP Role of Transition Team Lead

The Transition Coordinator is responsible to take the lead role in coordinating the transition planning process with the individual/family and all team members. This lead role will include assuring ongoing communication and coordination with everyone involved throughout the process from the day of referral until the end of the individual's MFP eligibility.

Team meeting/planning process to support the role as transition team lead

- Prepare an agenda for each meeting.
- Send to the team prior to meeting.
- Manage meeting using the agenda.
- Utilize the Transition Plan at meeting-List Action steps and identify who is responsible to address each action step/task in the plan.

Prior to meeting:

- Meet with the individual in transition and have them assist with preparing the meeting agenda so that their voice is the one heard by the team.
- If two CIL offices are involved, it would be important for the two-transition coordinator involved to have a pre meeting planning session to prepare for the meeting/agenda preparation etc.

After meeting is completed

- Provide a follow up email to the team members to communicate assigned tasks etc.

Informational Meeting Guidelines

Timeframe Requirements:

Prior to the Transition Team Meeting:

- Within 5 business days MFP Transition Coordinator will contact the social worker at the facility to schedule a time to explain the MFP process with the individual who expressed interest in transiting.
- Within 10 business days the MFP Transition Coordinator will meet with the individual to provide information on the MFP program and if the individual is interested the MFP consent should be signed by the individual and/or guardian.
- Within 3 days business days the MFP Transition Coordinator will provide the individual, the SNF, and MFP Referral Specialist a copy of the completed SFN 584.
    - If the referral is an 892 referral the MFP Transition Coordinator should inform the MFP Referral Specialist that individual is wanting to transition, and the team should be assembled.
- Within 5 business days of the signed MFP consent the MFP Transition Coordinator will contact the HCBS Case Manager, the MFP Housing Facilitator, SNF social worker, guardian, and any other people that the individual requests to schedule Transition Team meeting with the individual at the nursing facility/hospital.

The Transition Team Meeting:

- Within 14 business days of the signed consent, The Transition Team will meet with the **individual, HCBS Case Manager, MFP Housing Facilitator, SNF social worker and any family/staff** they would like to have present.
- MFP Transition Coordinator will facilitate the team meeting. Do we need more??

Transition Documents:

- MFP Transition Coordinator will complete within 30 days of signed consent the MFP Assessment with the individual.
- Within 2 weeks of the MFP Assessment being completed the MFP Transition Coordinator will development and complete the MFP Transition Plan. Should we add more about it being a living document?

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- During the first couple of meetings with the individual the MFP Transition Coordinator should start identifying risks within the Risk Assessment & Health and Safety Plan. The identified risks should also be addressed within the MFP Transition Plan.
- Within 7 days of transition the Risk Assessment & Health and Safety Plan should be fully completed with all risks mitigated and signed by the MFP Transition Coordinator and individual.
- Complete the MFP Emergency Backup Plan by day of transition, upload to Transition Documents in Therap and notify MFP Admin staff. The MFP Emergency Backup Plan should be typed, printed, and given to the individual on day of transition.

Purpose of Informational Meeting:

- Discuss the individual's desire to relocate to the community, available services options, and how the MFP transition team can support a transition to the community.
- Family members/legal representative and SNF social worker will be invited with the individual's consent.
- This is an informational meeting to secure consent to participate in MFP Grant Demonstration.

MFP Transition Coordinator is Responsible to:

- Assure eligibility criteria is met for MFP Grant Demonstration.
- Explain the MFP grant and obtain signature on the MFP Consent form *DN 881*
- Explain Center for Independent Living (CIL) services as Transition Coordinator.
- Explain Transition Role Matrix *DN 894*
- Explain consumer rights of MFP and CIL.
- Obtain Release of Information (ROI) to Nursing Facility, MFP, CIL, HCBS and give MFP, CIL information on appeals, and program brochures.
- Copies of the MFP *SFN 584* will be provided to the individual, Nursing Facility Social Worker, and upload to Transition Documents in Therap, then notify the MFP Referral Specialist.
- Provide the Individual transitioning with a copy of all documents.
- MFP Transition Coordinator will start a file for the individual to keep their own copies of everything to support the individual to develop skills in organizing and handling their own records.
- (Optional) Obtain Nursing Facility Care-Plan/Medication Administration Record/Face Sheet/Doctors Orders/Level of Care and upload to Transition Documents within Therap.

Document meeting in the MFP Referral Case Note in Therap

Forms to upload in Transition Documents:

- *DN 881:* MFP Consent From
- *SFN 584:* Skilled Care Referral for Long-term Services and Supports
- *SNF Care Plan/Medication Administration Record/Face Sheet/Doctors Orders/Level of Care*

Forms to provide to Individual:

- *DN 1367:* MFP Fact Sheet
- *DN 1368:* Independent Living Philosophy and Person-Centered Planning
- *DN 894:* Role Matrix
- *DN 1369:* MFP Guardianship Expectation (if applicable)
- MFP Brochure
- Provide Transition Team Information for review before full team meeting.

First MFP Transition Team Meeting

Transition Team Meeting:

Meeting must be within 14 business days of consent.

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The MFP Transition Coordinator will coordinate the initial Transition Team meeting with the individual/family, the HCBS Case Manager, the Housing Facilitator, and nursing facility social services staff to begin the planning for transition to the community.

***Purpose**:*

- Understand the transition goals, services, and supports needed for the individual.
- Each team member will provide a brief review of their role and services.
- MFP/HCBS/Housing will jointly complete needed documentation.
- MFP Transition Plan process will begin.

MFP Transition Coordinator Role:

- Obtain Nursing Facility Care-Plan/MAR/Face Sheet/Doctors Orders/LOC if not already received. (Optional)
- Explain process of Person-Centered/Independent Living planning.
- Offer a Peer Visiting opportunity. How should we train them on this?
- Review MFP Transition Assessment concerns with team, in the development of the MFP Transition Plan.
- Develop any Action Plans that are the reasonability of the Nursing Facility.
- Continue to setup future transition team meetings throughout the course of transition with individual, Nursing Facility Social Worker, HCBS Case Manager, MFP Housing Facilitator, and family.
- Ask Nursing Facility staff to start thinking about steps for discharge planning.
- **If not already completed: Document meeting in the MFP/ADRL Referral and Team Meeting Case Note in Therap.**

MFP Transition Coordinator Reminders:

- Any report of neglect or abuse, follow-up with appropriate referral sources (DD, Protection & Advocacy, and Ombudsman) along with Nursing Facility.
- Discuss importance of frequent Transition Team and Nursing Facility Social Services Worker communication.
- Prepare for transition/discharge planning meeting with Nursing Facility Team.

MFP Housing Facilitator Role:

- Provide Housing Information and discuss the role of Housing Facilitator.
- Secure information for any housing related goals for their MFP Transition Plan. Should housing facilitators enter the own housing goals?

HCBS Case Manager Role:

- Explain the role of the HCBS Case Manager
- Review of HCBS Services
- Review QSP Information
- Complete any required forms/assessments depending on date of discharge.

Transition Team Meeting (Meeting to plan the move home)

MFP Pre-Meeting Tasks:

- MFP Transition Coordinator schedules first Transition planning meeting after the completion of the Transition Team Meeting and assessments are conducted by the transition team members.
- MFP Transition Coordinator invites individual/family/legal representative, pertinent nursing facility staff, HCBS Case Manager and MFP Housing Facilitator to the Transition planning meeting as appropriate based on when the transition is anticipated.

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Transition Planning Meeting:

Tasks:

- Nursing Facility Social Worker/MFP Transition Coordinator jointly facilitates transition planning meeting.
- Offer a peer visiting opportunity.
- Transition Team members review their role in the process of transition planning with the individual, family members, legal representative, and Nursing Facility staff.
- Team discusses strengths, abilities, and wishes/goals of the individual through person centered focus.
- Each team member should address area of need at transition planning meeting and define appropriate referrals.
- Team reviews assessments and identified risks (Risk Assessment and Health and Safety Plan) that may need to be mitigated upon transition.
- Team will identify barriers to transition and develop action steps within the MFP Transition plan to address the barriers.
- Team recommends additional assessments/screenings/action necessary to mitigate risk factors.
- Input from transition/discharge planning meeting will utilized in the MFP Transition Plan and Nursing Facility transitional care-plan.
- Form:
    - *MFP Assessment.*

HCBC CM: Tasks as needed for service planning.
Housing Facilitator: Housing related search/application activities as needed.

Develop MFP Transition Plan

MFP Transition Coordinator Roles:

- MFP Transition Coordinator will prepare the MFP Transition Plan in Therap with Individual, family, HCBS Case Manager, MFP Housing Facilitator, legal representative, nursing facility staff.
- MFP Transition Coordinator will advocate and uphold individual's wishes for the MFP Transition Plan
- Offer a Peer Visiting opportunity.
- Utilize input from team meetings and assessments to develop MFP Transition Plan.
- Address identified risk and risk mitigation factors in the MFP Transition Plan.
- Nursing Facility Social Worker will document any action they will take in support of the of transition goals in the facility care plan. Any Action Plans that are identified by the Nursing Facility Social Worker will be inputted into the MFP Transition Plan by the Transition Coordinator.
- MFP Transition Coordinator will provide copies of the MFP Transition Plan for the individual, family, legal representative, and Nursing Facility Staff.

Documentation:

- MFP Transition Plan, Team Meeting Case Notes, Case Management Case Notes and MFP Documents as needed.

HCBS Case Manager Role:

- HCBS Case Manager will participate in the MFP Transition Plan in the timeframe established in policy.

MFP Housing Facilitator Role:

- Develop a housing Action Plan within MFP Transition Plan.

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- Complete Case Management Case Notes on housing progress.

Documentation: Housing Services Referral Assessment, Case Management Case Notes

Implementation of MFP Transition Plan

The MFP Transition Coordinator is responsible for communicating and assigning objectives/goals from the PCP/Transition Plan to the Transition Team as identified.

Implementation of Person-Centered Plan Goals:

- Start with long-range goals first: Ex: Accessible housing, Social Security, home modifications, QSP services, durable medical equipment, screenings/assessments etc.
- Referrals to outside providers, such as ND Assistive, QSP Agency, Protection & Advocacy (P&A) if applicable, etc.
- Submit any requests for MFP for moving costs as identified.
- Once long-range goals are progressing, start on skills training goals of teaching consumer skills to live independently, filing out needed applications, identifying needed household furnishings, medication issues, household services, etc.

HCBS CM
Housing Facilitator

Ongoing Transition Team Meetings as Needed:

- Progress reports given by each team member including individual self-reporting.
- Discharge transition date set depending on progress towards transition goals.
- Special team meetings can also be arranged to problem solve, etc. such as OT and PT meeting together with individual, Nursing Facility Social Worker, MFP Transition Coordinator, HCBS Case Manager and MFP, Housing Facilitator to brainstorm problems. Upon discretion of the MFP Transition Coordinator to seek out info and meetings with Nursing Facility staff to benefit the individual transitioning.
- OT should conduct accessibility evaluation of home before transition and recommend equipment, safety features in home, etc.
- Submit additional transition moving cost requests to MFP if necessary.
- MFP Transition Coordinator to invite HCBS Case Manager/Housing Facilitator to any team meetings as needed.
- Arrange for informal meetings/communication with Nursing Facility Staff or other agencies as needed to support the transition.

Forms:

- *SFN 542*: Transitions Assistance Request: (moving related spending requests)
- *SFN: 1958*: Transition Adjustment Support Services requests
- *SFN 774*: Rental Assistance Application

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HCBS Case Manager
Housing Staff

Final Transition Preparation???

MFP Transition Coordinator Role:

Review of goals/tasks:

- **Review MFP Discharge Checklist and complete needed tasks.**
- A transition team member (transition coordinator or housing facilitator) will complete a home visit prior to the day of transition to assure home preparedness.
- Prepare for transition day: Plan for medications, prescriptions, medical supplies, equipment, money, groceries, transportation, etc.
- Attempt to schedule transition early in the week.
- The Transition Coordinator should plan to spend the entire workday assisting the individual.
- Order needed furniture, Assistive Technology,
- Assure home modifications are completed.
-

Emergency Back Up Plan:

- Complete emergency back-up plan *SFN 926*
- Identify the frequency of 24-Hour Nurse Call Service contact.

Optional Support/Actions:

- Complete request for Transition Adjustment Support Services if needed.
- Forms:
    - SFN 1958: Authorization to provide Transition Adjustment Support Services
    - SFN 1956 Transition Adjustment Support Services Billing Worksheet

Risk Agreement:

- If concerned about choices or decision of the individual placing them at increased risk of outcomes that will jeopardize their success in the community.
- Form:
    - SFN: 1955 Risk Agreement

Case Manager

HCBS Transition Cases when moving home:

The week before (Current or Sending CM)

- Follow up with provider; make sure they start the day of discharge.
- Check ERS? Does it need to be set up before moving home (MFP can pay for set up)

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- Do they need Nurse Ed for med setup or other tasks that need to be done day of discharge? (This can be done prior to discharge and MFP can pay for)
- Current CM sets up meeting with the receiving CM and the MFP workers in both the current and receiving areas to review last minute details.
- As soon as we know a date of discharge, CM contacts the LTC unit and continues to follow up with LTC unit up until the date of discharge.
- Medications (follow up with NH on meds going with the person day of, pharmacy), etc
- CM contacts HHC agency if involved to see when starting, tasks that HCBS will do and what tasks HHC provider will do.
- If it is a referral for adult agency foster care, the CM reaches out to the provider and gives them general information. If they want to proceed, then the CM can work with the receiving CM and Supervisor to set up a more specific meeting with the home provider and client and MFP to discuss specifics.
- Full Participant assessment is completed, Risk Assessment is copied over from MFP and added to reflect current situation at home, PCP is done (review MFP Transition Plan and incorporate into PCP).
- Make sure that LOC screening is done for all MW, MSP B & C services.

Transition Day

MFP Transition Coordinator Role:

MFP Transition Coordinator is responsible to assure that all services are in place to meet the needs of the individual upon transition to the community including transition adjustment support services.

MFP Transition Coordinator will:

- **Review MFP Discharge Checklist and complete needed tasks.**
- Be at the home on day of transition. The Transition Coordinator should plan to spend the entire workday assisting the individual.
- Remain flexible and keep a positive attitude!
- Transition Coordinator or Housing Facilitator will have the keys to house or apartment.
- Attempt to avoid discharge on Mondays, Fridays, Holidays, weekends.
- Assist individual to obtain medications, prescriptions, and medical supplies, from Nursing Facility nurse.
- Assure a new pharmacy has been established and all scripts have been sent to the individual's pharmacy to be filled.
- Arrange for groceries/food for first week.
- Assist Individual to obtain resident trust fund monies from business office of Nursing Facility.
- Relocate individual to community living situation.
- Assure backup services are in place, including emergency response system (ERS).
- Notify MFP Program Team of transition.
- Provide MFP Program Team with copies of the typed Back-Up Plan
- Provide the individual with a copy of their Back-up Plan
- Document MFP/ADRL Transition Case Note in Therap

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Home and Community Based Services (HCBS) Case Manager Role:

Day/week of discharge (Receiving CM)

- The week of discharge, the CM goes to the home to do face to face visit in the home.
- CM follows up with QSP the first week that the person returned home (adequate services, time authorized)
- MFP does SNAP, LIHEAP, Social Security, Housing, clothing, household items.
- Ongoing: CM need to be inviting the MFP worker to all assessments 6th month and annual. If concerns invite to quarterlies also.

Housing Facilitator Role:

- **Assist with move into the apartment as able with the other team members.**
-

Ongoing Planning/Transition Support (After Transition Home)

The MFP Transition Coordinator will assist the individual with all planning needs post transition to support successful community living in cooperation with the Transition Team.

The team will identify additional HCBS or other community service options for the individual to consider as needed.

Role of MFP Transition Coordinator for One Year After Transition:

- Always work with individual, family, and legal representative, and transition team members to assure services are meeting the needs of the consumer.
- Adjust Person-Centered Plan/MFP Transition plans after the transition, as goals are met or needs change.
- Educate individual and team on incident reporting requirements.
- Educate individual on the emergency backup plan and Nurse Call number.
- Educate on emergency preparedness responses as needed.
- Post emergency contact # within home.
- Invite HCBS Case Manager/MFP Housing Facilitator to team meetings as needed.

Role of HCBS Case Manager for One Year After Transition:

- HCBS Case Manager will revise Person Centered Plan, if necessary, as support needs change.

Role of MFP Housing Facilitator for One Year After Transition:

- Housing staff will remain available after MFP to support tenancy as needed**.**

MFP Minimum Contacts

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Ongoing Visitation/Follow-up by MFP Transition Coordinator:

First week:
Be at the home on day of transition. The Transition Coordinator should plan to spend the entire workday assisting the individual.

Contact will be based on the adjustment needs/preferences of the Individual. This will range from just the day of transition to daily contact.

Ongoing contact: (Document all contacts in Case Management Therap Case Notes)
Home visits will be based on need of individual and as identified by the MFP Transition Coordinator with the individual and their team with a minimum of monthly contact.

Routine Scheduled Contacts:

- First Month: At least weekly in person contact within the home
- Second and Third Months: Minimum of in person contact within the home once every two weeks.
- Months four through twelve: Minimum of monthly in person contact within the home.

General Event Reports (GER) for all critical Incidents

- General Event Reports will be completed from day of transition until termination of MFP Services
- A General Event Report will need to be completed in the Therap System within 5 business days of the Transition Coordinator being notified of the incident.

Form: *Therap Critical Incident Submission Portal*: General Event Report

List of potential critical incidents to report in a GER:

Abuse	Neglect	Exploitation	Rights Violations
Serious Injury	Missing Person	Death	Medical Emergency
Medical Errors	Restraint	Law Enforcement Contact	Suicide Attempt

Hospitalization or Nursing Home Re-institutionalization

After Hospitalization or Nursing Home admission:

Follow-up action needed by MFP Transition Coordinator after a Short-Term Hospitalization or Short-Term Nursing Facility Readmission.

- Complete a GER Report.
- Complete the Re-institutionalization Case Note in Therap
- Inform the MFP Administrative Team of readmission by SComm
- Work with current service team to assess supports and services that need to be in place for successful return home.
- Update MFP Transition Plan

Return to community after a readmission

- Upon Discharge from the hospital or nursing facility the TC will complete the return to community case note in Therap
- Notify MFP Admin team by Scomm
- Update emergency back-up plan prior to return to the community.

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Dis-enrollment Criteria of MFP:

Individual is dis-enrolled when:

- Residing in institution for over 30 days.
- The 365 days of MFP eligibility clock stops at day 31 and only start again when they return to the community.
- If the individual is re-institutionalized, but is expected to return home within six months:
    - Request the Nursing Facility Social Worker to assist the individual's physician to prepare a letter to the Medicaid agency related to the plan for return to the community.

Re-enrollment to MFP Grant:

- Identify reasons for the institutionalization.
- MFP Transition Coordinator will review assessment/Person Centered Plan (IL Plan)/Risk Plan/Backup Plans and update as the need dictates.
- Transition Team will work with the individual, family and legal representative and institutional provider to identify services necessary to successfully return to the community.
- HCBS Case Manager completes any needed changes to assessment and Person-Centered Plan, as necessary.
- MFP Housing Facilitator completes any changes to any housing related Person-Centered Plan goals.
- MFP Transition Coordinator develops additional Person-Centered Plan/IL goals as needed to support the individual's return to the community.

- ## Termination of MFP Services

- Communicate with the Individual and other team members the ending of the MFP Transition Coordination Service.
- Identify any role the CIL will have after the termination of MFP services.
- Communicate with the HCBS Case Manager and MFP Housing Facilitator about ongoing follow-up at the end of MFP Services.
- Assure services and supports are in place for continued success.
- Complete any required MFP termination Level of Care Screening if needed at 11 months if the individual is not receiving Medicaid State Plan-Personal Care Level B or C, HCBS Waiver or PACE Services
- **Complete Termination of MFP/ADRL Questionnaire/Case Note in Therap**

Therap System

The MFP Grant documentations will be completed in the Therap Case Management System

- The MFP assessment will be completed in the Therap Vision Tool with additional information included in the MFP Risk Assessment and PCP/Transition Plan Case Note
- The MFP Person-Centered/Transition Plan will be completed using the Vision Tool in Therap with additional information noted in the MFP Risk Assessment and PCP/Transition Plan Case Note
- Critical Incident Reports will be completed in the Therap System.
- Transition Coordination staff will document all MFP activities in the case notes section of Therap.
- Documents will be added to the Therap System in the Individual Demographic Form section.
- The Therap SComm will be utilized to exchange information or make requests for approval of transition related spending.

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MFP Therap Case Notes

- Case Management
- MFP/ADRL Referral
- MFP Risk Assessment and PCP/Transition Plan
- Transition Case Note for MFP and ADRL
- Termination Case Note for MFP and ADRL

Individual Demographic Form (IDF)

Provides basic Demographic information about the individual receiving services.

At the bottom of the IDF Page you can find a menu of options to search including "Attached Files"
"Attached Files"-This allows the TC to upload the MFP documents including the following:

- MFP Consent
- MFP Backup Plan
- Completed SFN 584

General Event Reports (GER)

- The General Event Report is utilized for all incident that occur after a discharge to the community occurs.

SComm

- The Therap SComm will be utilized to exchange information or make requests for approval of transition related spending.
  Message Type(s)
  Compose:
  - General
  - Individual Care

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