



Money Follows the Person Transition Final Checklist

To be submitted after the transition occurs. All tasks and information must be completed in order for transition coordination payment to be authorized.

Date: _____
Participant's Name: _____
Participant's Medicaid Number: _____
LEAD Agency's Name: _____
Transition Coordinator Name: _____
TAX ID/ EIN # (required): _____
Phone: _____ **Fax:** _____
Transition Date: _____

Request submitted by:

- CAP DA/CHOICE
- PACE
- MCO
- DVR-IL
- CIL

Task	✓	Notes
Initial Transition Planning Conversation Held		Date:
Final Transition Planning Conversation Held		Date:
Final Transition Plan submitted to MFP		Date:
Final briefing meeting with MFP held before transition occurred.		Phone meeting is sufficient Date:
First transition follow up meeting with participant		Date Scheduled:
Did Medicaid County change? __Yes __No		If yes, what County?
Who is the follow along LEAD Agency? Example: CAP/DA, PACE, CCNC, MCO		Name: Phone #

Address of Participant's Community Residence in North Carolina

Street:			
City:	County:	Zip:	
Phone #:	Alternate Phone #:		

Final Living Arrangement (Check one)

In own home <input type="checkbox"/>	In relative's home or apartment <input type="checkbox"/>	In apartment <input type="checkbox"/>
AFL <input type="checkbox"/>	Or In 4-bed or less group home (4 unrelated individuals) <input type="checkbox"/>	

Waiver Program (Check one)

Waiver program Participant enrolled in:
 ___ CAP DA ___ CAP Choice ___ PACE ___ Sub CAP ___ Innovations

 Transition Coordinator's Signature _____ Date

 Authorized Signature of Sponsoring Lead Agency Representative _____ Date

 MFP Project Authorized Signature for Approval _____ Date

MFP Use only: Date Submitted to Budget Office _____	Amount \$ _____
Billing Code _____	Memo Line _____