WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Take Me Home Transition Program
Pre-Transition Assessment Tool

PARTICIPANT BACKGROUND INFORMATION

Last Name	First Name	Social Security No.	Medicaid No.	Date of Birth	Anticipated Transition Date

1. WHAT WERE THE REASONS FOR ENTERING THIS FACILITY?

- ☐ Treatment of medical condition, illness or injury
- ☐ Health or personal care problems while in the community
- ☐ Unable to return home from hospital or rehabilitation facility
- ☐ Difficulty in maintaining community residence
- ☐ Home modification or accessibility issues
- ☐ Community and/or informal supports did not meet my needs
- ☐ Financial problems
- ☐ Family conflict or loss of family support
- ☐ Adult Protective Services recommendation
- ☐ Other

2. WHO MADE THE DECISION FOR YOUR MOVE TO A FACILITY

- ☐ Self
- ☐ Family
- ☐ Legal Representative
- ☐ Doctor
- ☐ Court Ordered
- ☐ Other

3. WHAT BARRIERS WOULD YOU ANTICIPATE TO LEAVING THE FACILITY

- ☐ Family Objections
- ☐ Lack of informal support
- ☐ Housing
- ☐ Transportation
- ☐ Language or Communication
- ☐ Financial limitations
- ☐ Obtaining food
- ☐ Obtaining medications
- ☐ Other
- ☐ None

4. HAVE YOU BEEN NOTIFIED THAT YOU WILL HAVE TO MOVE FROM THE FACILITY

- ☐ Yes
- ☐ No

5. WHAT SUPPORTS COULD YOU RECEIVE FROM FAMILY AND/OR FRIENDS?

- ☐ None
- ☐ Financial assistance or management
- ☐ Furniture and/or household items
- ☐ Direct care assistance or management
- ☐ Shopping and/or errands
- ☐ Medication administration
- ☐ Not Sure
- ☐ Health management
- ☐ Moving assistance
- ☐ Guardianship
- ☐ SSA Payee
- ☐ Housing
- ☐ Transportation and/or management
- ☐ Other

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SECTION A. HOUSING

6. PHYSCIAL ADDRESS OF PROPERTY:

7. DIRECTIONS TO PROPERTY:

8. TYPE OF RESIDENCE:

☐ Owned by participant ☐ Owned by family/friend ☐ Rented Unit / Home

9. WILL ANYONE BE LIVING WITH YOU? LIST NAME, RELATIONSHIP, CONTACT INFORMATION

☐ Yes
☐ No

10. DO YOU HAVE A CRIMINAL HISTORY OR IS THERE ANY FAMILY HISTORY OF CRIMINAL ACTIVITY?

☐ Yes
☐ No

11. WILL THERE BE CHILDREN UNDER THE AGE OF 18 IN THE HOME?

☐ Yes
☐ No

12. IF YES, IS THERE ANY HISTORY OF OR CURRENT INVOLVEMENT BY CHILD PROTECTIVE SERVICES OR UNRESOLVED CUSTODY ISSUES?

☐ Yes
☐ No

13. DO YOU HAVE FURNITURE OR OTHER PERSONAL BELONGINGS THAT CAN BE MOVED TO YOUR RESIDENCE?

☐ Yes
☐ No

14. DO YOU NEED HOUSEHOLD ITEMS FOR YOUR NEW RESIDENCE?

☐ Yes
☐ No

15. IF YES, DO YOU HAVE ASSISTANCE, OR WILL YOU NEED ASSISTANCE OBTAINING THESE HOUSEHOLD ITEMS?

☐ Yes
☐ No

16. WILL SOMEONE BE AVAILABLE TO HELP YOU MOVE FURNITURE AND/OR PERSONAL BELONGINGS? IF YES, NAME AND CONTACT INFORMATION.

☐ Yes
☐ No

17. WILL YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING?

☐ Paying for initial housing costs (deposits, utilities, etc.)
☐ Modifications to existing housing
☐ Other

Last Name | First Name | Medicaid No.

SECTION B. PHYSICAL AND MENTAL HEALTH

18. WHICH DOCTOR(S) OR SPECIALISTS DO YOU SEE?

☐ Primary Care Physician - Nursing Facility ☐ Primary Care Physician - Private ☐ Specialists ☐ Other

19. WILL THESE BE THE SAME DOCTORS YOU SEE IN THE COMMUNITY

☐ Yes
☐ No

20. DO YOU KNOW WHAT MEDICATIONS YOU TAKE AND HOW THEY ARE TO BE TAKEN?

☐ Yes
☐ No

21. DO YOU HAVE UNTREATED DENTAL NEEDS?

☐ Yes
☐ No

22. DO YOU HAVE UNTREATED VISION NEEDS?

☐ Yes
☐ No

23. DO YOU HAVE UNTREATED HEARING NEEDS?

☐ Yes
☐ No

24. HAVE YOU EVER BEEN DIAGNOSED WITH DEMENTIA (Refer to #34 on the PAS)

☐ Yes
☐ No

25. HAVE YOU EVER BEEN DIAGNOSED WITH A MENTAL HEALTH CONDITION? (REFERENCE #30 ON THE PAS)

☐ Yes
☐ No

26. HAVE YOU EVER BEEN TREATED FOR A MENTAL HEALTH CONDITION? (REFERENCE #31 ON THE PAS)

☐ Yes ☐ No
☐ Inpatient treatment facility
☐ Outpatient treatment facility
☐ Involuntary or voluntary commitment
☐ Other

27. ARE YOU CURRENTLY TAKING MEDICATION FOR A MENTAL HEALTH CONDITION?

☐ Yes ☐ MAR SHEET ATTACHED
☐ No

28. ARE YOU CURRENTLY RECEIVING TREATMENT OR COUNSELING FOR A MENTAL HEALTH CONDITION?

☐ Yes
☐ No

29. HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE? (REFERENCE #34 ON THE PAS)

- ☐ Yes
- ☐ No

30. HAVE YOU EVER BEEN TREATED FOR A SUBSTANCE ABUSE PROBLEM?

- ☐ Yes ☐ No
- ☐ Inpatient treatment facility
- ☐ Outpatient treatment facility
- ☐ Involuntary or voluntary commitment
- ☐ Other

31. ARE YOU CURRENTLY RECEIVING TREATMENT OR COUNSELING FOR A SUBSTANCE ABUSE PROBLEM?

- ☐ Yes
- ☐ No

32. HAVE YOU EVER HAD A LOSS OF A JOB, HOME OR FAMILY DUE TO SUBSTANCE ABUSE?

- ☐ Yes
- ☐ No

33. DO YOU HAVE A HISTORY OF ASSOCIATING WITH PEOPLE (INCLUDING FAMILY) WHO ABUSE OR USE DRUGS OR ALCOHOL?

- ☐ Yes
- ☐ No

34. DO YOU HAVE A HISTORY OF ASSOCIATING WITH PEOPLE (INCLUDING FAMILY) WHO ARE PHYSICALLY OR VERBALLY ABUSIVE OR TRY TO CONTROL YOU?

- ☐ Yes
- ☐ No

35. HAS THERE EVER BEEN CRIMINAL ACTIVITY IN THE HOME (BY YOU OR ANYONE ELSE WHO WILL BE LIVING IN THE HOME)?

- ☐ Yes
- ☐ No

SECTION C. DAILY LIVING - PERSONAL ASSISTANCE

36. HOW DID YOU MANAGE YOUR DAILY LIVING ACTIVITIES PRIOR TO ENTERING THE FACILTY?

- ☐ I managed my own daily living needs.
- ☐ I managed my own daily living needs with attendant services.
- ☐ Daily living assistance was provided by family and/or friends.
- ☐ Daily living assistance was provided by a community provider.
- ☐ Other

37. DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING DAILY LIVING TASKS? (REFER TO #26 ON PAS)

- ☐ Walking, using a wheelchair, cane or other mobility device
- ☐ Transferring from bed or a chair
- ☐ Eating
- ☐ Taking medications
- ☐ Toileting
- ☐ Bathing and/or personal hygiene
- ☐ Planning and/or preparing healthy meals
- ☐ Preparing grocery or shopping lists
- ☐ Shopping or errands
- ☐ Other

38. HAVE YOU EVER RECEIVED ANY OF THE FOLLOWING COMMUNITY SERVICES?

- ☐ None
- ☐ Aged and Disabled Waiver
- ☐ Traumatic Brain Injury Waiver
- ☐ I/DD Waiver
- ☐ Medicaid Personal Care Services
- ☐ Medicaid Home Health Services
- ☐ Medicare Home Health Services
- ☐ Behavioral Health Rehabilitation Services
- ☐ Behavioral Health Clinic Services
- ☐ Other

39. HAVE YOU EVER BEEN REFUSED SERVICES OR HAD SERVICES DISCONTINUED BY A DIRECT-CARE SERVICE PROVIDER?

- ☐ Yes
- ☐ No

40. HAS ADULT PROTECTIVE SERVICES EVER BEEN INVOLVED?

- ☐ Yes
- ☐ No

41. DO YOU NEED ASSISTANCE AND/OR SUPERVISION FOR YOU TO FEEL SAFE?

- ☐ A few hours a week
- ☐ Several hours a day
- ☐ Most of the day
- ☐ During the day, but I can be on my own at night
- ☐ All day (even when I'm sleeping)
- ☐ Other

SECTION D. EQUIPMENT - ASSISTIVE TECHNOLOGY

42. WHEN YOU LEAVE THE FACILITY, WILL YOU HAVE A NEED FOR ANY OF THE FOLLOWING?

EQUIPMENT:

- ☐ Wheelchair, cane, walker, or other device or prosthesis
- ☐ Shower bench or chair
- ☐ Transfer equipment and/or Hoyer lift
- ☐ Hospital bed or therapeutic mattress
- ☐ Incontinence supplies
- ☐ Other
- ☐ None

ASSISTIVE TECHNOLOGY:

- ☐ Hearing aids
- ☐ Communication device
- ☐ Amplification device
- ☐ Glasses
- ☐ Modified utensils
- ☐ Devices for operating lamps, radios, or other appliances
- ☐ Modified door knobs
- ☐ Medication organizers or prompting devices
- ☐ Other
- ☐ None

43. WILL YOU NEED ASSISTANCE WITH OBTAINING ANY OF THE ITEMS CHECKED IN QUESTION #47?

- ☐ Yes
- ☐ No

44. WILL YOU NEED ASSISTANCE IN LEARNING HOW TO USE ANY OF THE ITEMS CHECKED IN QUESTION #47?

- ☐ Yes
- ☐ No

SECTION E. TRANSPORTATION

45. WHAT TYPE OF TRANSPORTATION WILL YOU LIKELY HAVE AVAILABLE WHEN YOU GO HOME?

- ☐ Own vehicle - drive self
- ☐ Own vehicle - others to drive
- ☐ Family and/or friends provide transportation
- ☐ Community service provider
- ☐ Other community or civic organization
- ☐ Public transportation
- ☐ Para-transit system
- ☐ NEMT
- ☐ Other

46. IF PUBLIC TRANSPORATION OR PARA-TRANSIT SYSTEM IS AVAILABLE , DO YOU NEED ASSISTANCE COMPLETING THE APPLICATION PROCESS?

- ☐ Yes
- ☐ No

47. IF PUBLIC TRANSPORATION OR PARA-TRANSIT SYSTEM IS AVAILABLE , DO YOU NEED ASSISTANCE LEARING TO HOW TO USE IT?

- ☐ Yes
- ☐ No

48. IF YOUR INITAL TRANSPORTATION OPTION IS UNAVAILABLE, WHAT OTHER OPTIONS MIGHT YOU CONSIDER? PLEASE EXPLAIN

SECTION F. SOCIAL - FAITH - RECREATION

49. DO YOU HAVE FAMILY AND/OR FRIENDS IN THE AREA?

- ☐ Yes
- ☐ No

50. IF YOU HAVE FAMILY AND/OR FRIENDS NEARBY, HOW OFTEN DO YOU SEE THEM?

- ☐ More than once a week
- ☐ Once a week
- ☐ Once a month
- ☐ Infrequently
- ☐ Never
- ☐ Other

51. WOULD YOU LIKE TO HAVE MORE CONTACT WITH FAMILY AND/OR FRIENDS?

- ☐ Yes
- ☐ No

52. DO YOU HAVE A LOCAL PLACE OF WORSHIP WHEN YOU RETURN HOME?

- ☐ Yes (LIST CONGREGATION, CONTACT, NAME, AND PHONE NUMBER
- ☐ No - Don't want one
- ☐ No - Would like one

53. WHEN YOU LEAVE THE FACILITY, WILL YOU NEED ASSISTANCE FINDING OR ACCESSING ANY OF THE FOLLOWING?

- ☐ Place of worship
- ☐ Senior Center
- ☐ Recreation center
- ☐ Support group
- ☐ Other

54. DO YOU HAVE ANY HOBBIES OR INTERESTS YOU WOULD LIKE TO CONTINUE OR RESUME AFTER MOVING HOME?

- ☐ Yes
- ☐ No

SECTION G. EMPLOYMENT OR VOLUNTEERISM

55. WHEN YOU LEAVE THE FACILITY, WOULD YOU BE INTERESTED IN WORKING AND/OR VOLUNTEERING?

- ☐ Yes
- ☐ No

56. DO YOU HAVE ANY EMPLOYMENT OR VOLUNTEERISM HISTORY?

- ☐ Yes
- ☐ No

57. WILL YOU NEED ASSISTANCE ACCESSING OPPORTUNITIES FOR EMPLOYMENT AND/OR VOLUNTEERING?

- ☐ Yes
- ☐ No

58. WILL YOU NEED ASSISTANCE ACCESSING EDUCATIONAL OR TRAINING OPPORTUNITIES OR ACTIVITIES?

- ☐ Yes
- ☐ No

SECTION H. FINANCIAL AND PERSONAL RESOURCE MANAGEMENT

59. WILL YOU NEED ASSISTANCE WITH AN Y OF THE FOLLOWING IN ORDER TO TRANSITION TO THE COMMUNITY?

- ☐ Establish legal representative
- ☐ Change legal representative
- ☐ Create a living will or advance directive
- ☐ Establish a payee
- ☐ Establish a bank account
- ☐ Establish direct deposit
- ☐ Transfer Social Security benefits
- ☐ Apply for food stamps
- ☐ Change of address
- ☐ Other

60. WHAT ARE YOUR MONTHLY INCOME SOURCES

- ☐ Social Security Income
- ☐ Social Security Disability Income
- ☐ Retirement or pension
- ☐ Veteran's benefits
- ☐ Spousal benefits
- ☐ Supplemental Security Income (SSI)
- ☐ Other

61. WILL YOU NEED FINANCIAL ASSISTANCE TO PAY FOR TRANSITION START-UP COSTS (COMMUNITY TRANSITION SERVICES)?

- ☐ Yes
- ☐ No

62. WILL YOU NEED ASSISTANCE WITH DEVELOPING A MONTHLY BUDGET AND/OR WITH MONEY MANAGEMENT?

- ☐ Yes
- ☐ No

63. DO YOU HAVE ANY UNPAID UTILITY BILLS OR OTHER ON-GOING DEBTS?

- ☐ Gas
- ☐ Electric
- ☐ Water
- ☐ Sewer
- ☐ Phone
- ☐ Trash
- ☐ City Fees
- ☐ Credit cards
- ☐ Loan debts or defaults
- ☐ Mortgage or rent
- ☐ Other
- ☐ None

64. WOULD YOU LIKE TO MEET WITH A COUNSELOR FROM A CREDIT COUNSELING CENTER?

- ☐ Yes
- ☐ No

65. DO YOU HAVE ANY UNRESOLVED LEGAL ISSUES?

- ☐ Unpaid ticket(s) or fines
- ☐ Bench warrants
- ☐ Restraining orders
- ☐ Felony convictions
- ☐ Other
- ☐ None

ADDITIONAL INFORMATION

66. DO YOU HAVE ANY QUESTIONS OR CONCERNS THAT HAVE NOT BEEN COVERED?

- ☐ Yes
- ☐ No

67. ADDITIONAL INFORMATION FROM PREVIOUS QUESTIONS:

AUTHORIZING SIGNATURES (If Participant signs with a mark, two witnesses are required).

Signature of Participant or Legal Representative | Date of Signature | Signature of Witness | Date of Signature

Signature of Transition Coordinator | Date of Signature | Signature of Witness | Date of Signature

Transition Coordinator Name