Health & Human Resources — Bureau for Medical Services

Take Me Home Transition Program
Risk Analysis and Mitigation Tool

PARTICIPANT INFORMATION

Last Name	First Name	Medicaid No.	Date of Birth	Transition Date	Waiver Program

SECTION A. RISK IDENTIFICATION

1. HEALTH, MEDICAL & NUTRITION	2. ADLs and SAFETY	3. BEHAVIORAL AND LIFESTYLE	4. MEDICATIONS	5. HOME AND INFORMAL SUPPORTS	6. OTHER POSSIBLE RISKS
Chronic health conditions	Food and liquid intake	Endangering self (or self-neglect)	Multiple prescriptions	Informal support capacity	Hazardous dwelling
Mental health	Meal preparation	Endangering others	Medication complications	Limited support system	Sanitation
Access to medical care	Dressing and Grooming	Destruction of property	Psychotropic medications	Service refusal	Neighborhood
Treatment compliance	Ambulation	Aggression	Use of OTC or herbal medicines	Social Opportunities	Accessibility
ER Visits and/or hospitalizations	Transfers	Substance abuse	Medication compliance	Isolation	Community access
Nutrition and/or special diets	Toileting	Victimization or exploitation	Medication administration	Home stability and situation	Other
Skin breakdown	Bathing	Justice system involvement	Medication allergies	Housemate compatibility	
Seizures	Communication	Isolation	Other	Other	
Elimination	Falls	Inappropriate sexual behavior			
Aspiration	Injuries	Finances			
Other	Victimization	Homelessness			
	Emergency response	Other			
	Home maintenance				
	Other				

7. ANY ABUSE, NEGLECT OR EXPLOITATION CONCERNS (PAST OR FUTURE)? (If yes, explain in Question #8 Notes section.)

☐ Yes ☐ No

8. ADDITIONAL INFORMATION

Question #8 Notes

Last Name	First Name	Medicaid No.

SECTION B. RISK EVALUATION

SEVERITY OF OUTCOME: 1) Possibly harmful to health/welfare 2) Likely harmful to health/welfare 3) Immediately harmful to health/welfare 4) Debilitating or death
FREQUENCY OF RISK: 1) Rarely or Annually 2) Seasonally 3) Monthly 4) Weekly 5) Daily 6) More than daily

SIGNIFICANT RISK FACTOR(S) (from Section A)	SEVERITY OF OUTCOME	FREQUENCY OF RISK	DESCRIPTION OF CIRCUMSTANCES	COULD THIS POTENTIALLY JEOPARDIZE SERVICES?

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SECTION C. RISK MITIGATION PLAN

Significant Risk Factor(s)	What can be done to prevent or mitigate risk?	What strengths or assets does the participant have to reduce the risk?	What additional supports would be helpful in reducing the risk?	Who can help with prevention or mitigation of the risk?	Is the risk addressed in HCBS plan?(Y/N)

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SECTION D: CONTACTS

If Take Me Home staff are unable to reach me for a regularly scheduled Monthly Contact or other purpose, please contact the following individuals, who will know how I can be reached at all times:

Last Name	First Name	Home Phone	Cell Phone	Work Phone	Relationship

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

The participant agrees to the Risk Mitigation Plan? ☐ YES ☐ NO

Signature of Participant or Legal Representative

Date of Signature

Signature of Witness

Date of Signature

Signature of Witness

Date of Signature

Signature of Transition Coordinator

Date of Signature

Transition Coordinator Name