TC Initials_____________
Participant Initials _____________

Revised version- Final as of 9.9.08

Transition Coordinator Log

PHASE 1: Initial Meeting(s) with Transition Candidate

1. TC Name__________________

2. Date of 1st Mtg ________

3. Candidate's Name___________________________

4. Medicaid #____________________

5. Target Group

____Elderly ____ Person w/Physical Disability ____DD/MR

6. QExA Plan (circle one) Ohana Evercare

7. Facility Name __________________

8. Facility Type ____Hospital ____Nursing Facility ____ICF/MR

9. Island___________________

10. Date of Birth__________

11. Gender (circle) Male Female

12. Race/Ethnicity (check all that apply)

____American Indian or Alaskan Native
____ Asian

- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (specify)____________

____Native Hawaiian or Pacific Islander:

- ☐ Native Hawaiian
- ☐ Micronesian
- ☐ Samoan/Tongan
- ☐ Other Pacific Islander (specify):______________________

____ Black or African American (Not of Hispanic Origin)
____ Hispanic
____White (Not of Hispanic Origin)
____ Native American
____ Some Other Race (specify):____________________________

13. Primary Spoken Language
❑English ❑Other (specify):____________________

14. Need a Translator/ Interpreter Present ____Yes ____No

15. Persons Present (Please provide an unduplicated count of family/friends and staff/professionals present at all initial meetings)

Family/Friends________ Staff/Professionals________

16. Capable of self-consent? Yes________ No________
If no, who is responsible?
___ Family member
___Legal Guardian
___Durable Power of Attorney
___Other (explain)____

17. Confirm Eligibility
Date of Entry into Current Facility: ______________
Date of Entry into Previous Facility (must be continuous):______________
In a facility or multiple facilities for at least 6 months: ❑Yes ❑No
Medicaid for the last 30 days: ❑Yes ❑No

Date Eligibility Confirmed:____________

18. Review Informational Materials (date as discussed)
______ Brochure
______ FAQs
______ Rights and Responsibilities

19. Preference Interview

N/A because it is a hospital discharge ❑
Consent to interview? ❑Yes ❑No Date___________
Completed interview? ❑Yes ❑No Date___________
Final preference? (Q27 of interview) ❑Yes ❑No ❑Don't Know

If no, reasons: (Use the back of this paper as necessary)

TC Initials_____________
Participant Initials _____________

If don’t know, reasons:

What would it take to change the person’s mind?

Other comments:

20. Informed Consent

Read through informed consent and answered questions: ❑Yes ❑No

Signed MFP Informed Consent: ❑Yes, Date signed___________ ❑No

If No, Reasons:

21. Other Required Forms (If Yes to #19)

Consent to Release Medical Info signed: ❑Yes ❑No
HIPAA Form (privacy notice) reviewed and candidate given a copy: ❑Yes ❑No
Choice of Case Manager form: ❑Yes ❑No
ADF form: ❑Yes ❑No

22. Challenges/Special Needs

TC Initials_____________
Participant Initials _____________

23. Date stopped transition efforts (Phase 1) __________________

24. Why were transition efforts stopped?

___Too physically ill
___Too cognitively impaired
___Mental illness
___Guardian refused participation
___Could not locate appropriate housing arrangement
___Could not secure affordable housing
___Individual did not choose Going Home Plus qualified residence (own home/apt, public or subsidized housing, licensed or certified home w/ <4 individuals)
___Individual changed his/her mind
___Individual would not cooperate in care plan development
___Service needs greater than what could be provided in the community
___Other, specify: ____

Note: When this section is complete, or when transition efforts are stopped, please tear off this portion of the Transition Coordinator Phase 1 log and fax along with the completed preference interview (if applicable), and informed consent to Madi Silverman at (808) 692.8173. Please keep a copy for your records.

TC Initials_____________
Participant Initials _____________

PHASE 2: Assessment and Care Planning Meeting(s)

1. **TC Name_______________**

2. **Participant Name______________**

3. **Date of 1st Assessment and Planning Mtg __________**

4. Date that the ongoing case manager got involved and completed:
Health and social assessment _________
Service plan _______

5. Date stopped transition efforts (if transition planning stopped prior to discharge)
____

6. Why were efforts stopped?
___Too physically ill
___Too cognitively impaired
___Mental illness
___Guardian refused participation
___Could not locate appropriate housing arrangement
___Could not secure affordable housing
___Individual did not choose a Going Home Plus qualified residence (own home/apt, public or subsidized housing, licensed or certified home w/ <4 individuals)
___Individual changed his/her mind
___Individual would not cooperate in care plan development
___Service needs greater than what could be provided in the community
___ Other, specify:____

7. Date that Person Transitioned from the Facility_________________

8. Waiver Program Enrolled In ______________________________
*Note: #6 to be ignored/deleted after implementation of QExA

9. Quality of Life Survey (including 2 questions on Addendum)
___ Yes, Date completed: ______________
___ No, Reason:____

10. Participant's Housing Type
❑ Home/Apartment
❑ Subsidized Housing
❑ Group Home

If RACC Home, Caregiver Name: ____________________
Island______________
City _______________

TC Initials_____________
Participant Initials _____________

Is RACC Home: ❑ Permanent ❑Temporary

Is participant currently applying or on a waitlist for public housing? ❑Yes ❑No

11. Describe Participant's Housing Goals/ Preferred Housing (Use the back of this paper as necessary)

12. Describe Housing Challenges/Barriers

13. Supplemental Transition Services to be Used (e.g., housing deposit, utility hookup, furniture, appliance, and moving expenses, one-time cleaning. Complete for participants who move to home or apartment):

14. Demonstration Services

Transition Coordination
Number of Months TC Authorized Post-Discharge ________
Tasks to complete post-discharge:

Use of Telemedicine? ❑Yes ❑No
If Yes, Number of Months Authorized __________
Date of Equipment Installation__________________
Date of Telemedicine Training__________________

TC Initials_____________
Participant Initials _____________

Caregiver Training
Special Needs of Client (check all that apply):
❑Behavior
❑Obese
❑Skilled nursing
❑Other(s):____

Did the caregiver receive training from the Going Home Plus Training Institute?
❑Yes ❑No ❑Don’t Know

If Yes, Type(s) of Training:
❑Live-in training
❑One on One
❑In Facility

15. Describe Service Challenges/Barriers:

Note: When this section is complete, or when transition efforts are stopped, please fax this Transition Coordinator Phase 2 log and QoL survey+addendum to Madi Silverman at (808) 692.8173. Please keep a copy for your records.