LIVING CHOICE DEMONSTRATION PROJECT

Moving Day Checklist

Transition Coordinator Checklist		Date Completed
1. Transportation to community home arranged	☐	____________
2. Moving of personal belongings arranged/completed	☐	____________
3. Prescription medications obtained	☐	____________
4. Contact sheet completed/posted	☐	____________
5. Community physician appointment completed or scheduled	☐	____________
6. Change of address completed (SSI, USPS, etc.,)	☐	____________
7. Working phone in place	☐	____________
8. Utilities turned on – water, electric, gas (heat and/or AC)	☐	____________
9. Essential household items in place	☐	____________
10. Groceries in place	☐	____________
11. Community Service Plan authorized	☐	____________
12. Begin date for in-home services established	☐	____________
13. Emergency back-up plan established	☐	____________
14. Delivery date for medical equipment established	☐	____________

Participant Signature: ________________________________ Date: ________________

Transition Coordinator Signature: ________________________ Date: ____________

Participant Checklist	Date Completed
1. I have been involved in the decision about where I will receive care after I leave the nursing facility.	☐ ___________
2. I understand my medical condition and possible complications of my disease process(es).	☐ ___________
3. I understand what I can do to maintain my health as well as possible.	☐ ___________
4. I understand what my medications are, how to take them, and what side effects may occur.	☐ ___________
5. I understand the signs and symptoms that may require prompt medical attention, and who to call if they occur.	☐ ___________
6. I know the name of my community doctor and how to reach him/her.	☐ ___________
7. I know the date of my next doctor appointment and any medical tests I will need to have during the next several weeks, and I know how I will get to these appointments.	☐ ___________
8. I know which home care provider is assigned to assist me in my new home, what type of assistance is to be provided and how often, and how to contact them if there is a problem.	☐ ___________
9. I have a back-up plan established in the event a service provider is unavailable, and I know who to call to implement the plan.	☐ ___________
10. I understand what actions to take in the event of an emergency, and know where my emergency phone numbers are posted.	☐ ___________
11. I understand what medical equipment/supplies I need and when they are to be delivered. I know who to call if there are any problems with the delivery or the equipment.	☐ ___________
12. I know how and when to contact my Transition Coordinator, and how to make a complaint in the event I am dissatisfied with any of my services.	☐ ___________

Participant Signature: ____ Date: ____________________

Transition Coordinator Signature: ______________________________ Date: ____________________