

LIVING CHOICE DEMONSTRATION PROJECT

Nursing Home Transition
Overall Needs Checklist

Participant Name: _____

Transition Coordinator Name: _____

Needs (If applicable)	Date Completed
SoonerRide (medical transport)	<input type="checkbox"/> _____
Local community transportation	<input type="checkbox"/> _____
Birth Certificate	<input type="checkbox"/> _____
Driver's License/State ID	<input type="checkbox"/> _____
Social Security Card	<input type="checkbox"/> _____
Medicare Card	<input type="checkbox"/> _____
Medicaid Card	<input type="checkbox"/> _____
Bank Account	<input type="checkbox"/> _____
Direct Deposit	<input type="checkbox"/> _____
Transition Budget	<input type="checkbox"/> _____
Monthly Budget	<input type="checkbox"/> _____
UCAT Part I and III	<input type="checkbox"/> _____
Housing Applications	<input type="checkbox"/> _____
Household needs list	<input type="checkbox"/> _____
Community Doctor	<input type="checkbox"/> _____
Community Pharmacy	<input type="checkbox"/> _____
Food Stamps	<input type="checkbox"/> _____
Representative Payee	<input type="checkbox"/> _____
Support Groups	<input type="checkbox"/> _____
Life Planning	<input type="checkbox"/> _____
Emergency Contact List	<input type="checkbox"/> _____
Emergency Back-up Plan	<input type="checkbox"/> _____
Job Search/Volunteer Opportunities	<input type="checkbox"/> _____
Family/Friends	<input type="checkbox"/> _____
Other:	<input type="checkbox"/> _____
Other:	<input type="checkbox"/> _____
Other:	<input type="checkbox"/> _____