Transition Screening Tool

Idaho Home Choice – MFP

First Name: **M.I.:** **Last Name:** **Gender:** Male ◯ Female ◯

SSN: **Medicaid ID:** **Date of Birth:**

Initial Screening Date:

Has participant lived in an institution/facility for 90 consecutive days? ☐ Yes ☐ No

Does participant meet nursing level of care? ☐ Yes ☐ No

Does participant wish to live outside of the facility? ☐ Yes ☐ No

Will participant live in one of the following qualifying residence:

- ☐ Own Home
- ☐ Own Apartment
- ☐ Family's Home
- ☐ Community-Based residential setting with no more than four unrelated individuals residing (example: Certified Family Home)

Does participant have a guardian? ☐ Yes ☐ No

If yes, please include name and number:

Please include any information pertinent to participant's likelihood of success outside of institutional care: