Transitional Services Request/Referral Form

Transitional services: Items and expenses necessary and reasonable for a person to transition from an eligible setting to their own home or an integrated community supports setting.

Person's own home: For the purposes of this service, a person's own home is a setting they own, rent or lease that is not operated, owned or leased by a provider of services or supports. The person has full control of their housing and choice of service provider.

Eligibility: A person is eligible to receive transitional services if they meet all the following criteria:

- Age 18 or older, and are waiver eligible (BI, CADI, CAC, & DD).
- Moving from an eligible setting to their own home or an integrated community supports setting.
- Moving to a setting where these items and expenses are not normally furnished.
- Not able to access transitional services from other funding sources (e.g., community nonprofit organizations).
- Case manager will add service to CSSP, and service will not have been used within last 3 years.

REFERRING CASE MANAGER				
Agency:			Telephone:	
Address:			Fax:	
Name of Case Manager:			Email:	
CONSUMER INFORMATION				
Name:			Telephone:	
CFR:	Race:		DOB:	
Email:			Interpreter needed? Yes ☐ No ☐	
Diagnosis 1:		Code:	PMI #:	
Diagnosis 2:		Code:	CAC ☐ CADI ☐ BI ☐ EW ☐ DD ☐	

PROVIDER NAME	**NPI NUMBER**	**DESCRIPTION**	**PROCEDURE**	**MAXIMUM AMOUNT**
Caremark Home Health Care LLC	A1407476252	Household Items	T2038-U2 ☐	$300.00
Caremark Home Health Care LLC	A1407476252	Furniture	T2038-U1 ☐	$1000.00

Caremark Home Health Care LLC	A1407476252	Moving services Delivery Damage deposit Application fee Mileage Labor	T2038 ☐	$1700.00

Does the client have a spend down? Y☐ N☐ If yes, how much is the spend down? _____

Please check the services identified in the CSSP for the Transitional Service Coordinators to coordinate:	
☐	Move personal items from Licensed Facility or Storage Unit to Consumer's new home (movers will **NOT** pack, unpack, assemble, or disassemble)
☐	One-Time Pest and Allergen Treatment of Home
☐	Purchase One-Time Household/Cleaning Supplies/Furniture (SEE LIST BELOW)

(Only complete areas where movers need to pick items up from)

Current address	Name of facility:	
Address of facility:		
Room number:	Contact at facility:	
City:	State:	Zip:
Storage facility	Name of storage facility:	
Address of facility		
Unit number:	Code/Access:	
City:	State:	Zip:
New address	Name of Apartment Building:	
Address:		
Apartment #		
City:	State	Zip:

********Date of Move: _____**

Damage Deposit/Application Fee – T2038: YES NO (circle one) Amount $ _____

(Damage deposits will not be available until day of move. Letters of guaranteeing payment can be sent out by request).

Caremark Home Health Care LLC
Email: Ics.Caremark@gmail.com Phone: 612-399-9987 Fax: 952-487-4284

Name Payable for Security Deposit	
Telephone Number	
Address (for mailing the check)	
City	
State	
Zip Code	

Color preferences _____

(**based on availability and are not guaranteed/we will do our best**)

Apartment size: Studio ☐ 1-Bedroom ☐ 2-Bedroom ☐ 3-Bedroom ☐ (Check one)

Only check items needed

If all items are checked, some used furniture may be included.

**** Beds are Twin, unless size is an issue. *****

(T2038-U1) – Essential Furniture, not to exceed $1,000 of allowable $3,000.

☐	Bed frame	☐	Mattress	☐	Box spring	☐	Dresser
☐	Floor lamp	☐	TV stand	☐	Dining table/Chairs		(2 or 3 chairs, circle one)
☐	Nightstand	☐	Table lamp	☐	Sofa/couch		(2 or 3 cushions, circle one)

(T2038-U2) – Household Supplies, not to exceed $300 of the allowable $3,000.

☐	Coffee pot	☐	Silverware	☐	Comforter (list size)
☐	Toaster	☐	Dishes	☐	Sheets (list size)
☐	Clock	☐	Drinking glasses (4 plastic)	☐	Blanket (1) (list size)
☐	Pots/pans	☐	Dish rack with tray	☐	Hangers
☐	Kitchen linens	☐	Pillow (1)	☐	Kitchen garbage can
☐	Mixing bowls	☐	Shower curtain and rings	☐	Garbage bags
☐	3 pc knife set	☐	Bathroom linens	☐	Toilet paper
☐	Small cutting board	☐	Stick vacuum	☐	Paper towels
☐	Kleenex	☐	Sponge/dish soap	☐	Broom w/dustpan
☐	Hamper	☐	Cleaning supplies	☐	mop
☐	Laundry detergent	☐	Toilet brush	☐	Other:
☐	Microwave: (choosing this option means you won't be able to get every item listed above)				

Signature of Consumer: (optional) _____

Referring Case Manager Signature: _____ Date _____

Submit

Caremark Home Health Care LLC
Email: Ics.Caremark@gmail.com Phone: 612-399-9987 Fax: 952-487-4284