

8/19/14

MFP Participant Face Sheet – Form F

Date: _____ Participant Name: _____

Date of Birth: _____ RIN #: _____

Participant Address _____ Participant Phone #: _____

Emergency contact Name: _____ Emergency contact Phone #: _____

Transition coordinator name: _____ TC Phone #: _____

Participant's Height (ft/inches): _____ Ft _____ In _____ Weight (in pounds): _____

Gender: Male Female

Reason Admitted to Nursing Home (required): **[text area, 1000 characters]**

Have you or your agency worked with this consumer before? Yes No If yes, explain history:

Describe Family/Significant other/ Social support: **[text area, 1000 characters]**

Will Participant be living alone once Transitioned to the community?: Yes No

Explain: **[text area, 1000 characters]**

Type of potential Housing:

SLF _____ Housing Authority/Subsidy _____ Rental apartment/house _____ Family residence _____
Other _____

Briefly describe specific housing needs:

Primary Diagnoses:

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Add more...

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Sensory Needs/Impairments: [check boxes, allow more than one selection]

1. Vision:

- No issue
- Corrected/Uses Glasses
- Difficulty seeing with glasses
- Blind

6. Incontinence:

- No issue
- Urinary
- Bowel
- Urinary and Bowel

2. Hearing:

- No issue
- Corrected/Hearing Aide
- Hard of Hearing
- Deaf
- Interpreter needed

7. Skin:

- No issue
- Redness/irritation
- Breakdown/Wounds present
- History of chronic wounds

3. Speech:

- No issues
- Impaired/Aphasia
- Does not speak English
- Interpreter needed

8. Pain

- None
- Controlled with medication
- Chronic > 3 months
- Uncontrolled

4. Respiratory:

- No breathing problems
- Uses oxygen
- Shortness of Breath that limits mobility/activity

9. Neurological

- **None**
- Upper extremity paralysis
- Lower extremity paralysis
- Dysphasia

5. Mobility:

- No impairment
- Uses wheelchair
- Uses walker
- Uses cane

10. Behavioral:

- **None**
- Does not comprehend conditions/treatment
- Refuses/Unable to adhere to treatment plan
- Has self-harm behaviors
- Alcohol/substance use/abuse current
- Alcohol/substance use/abuse history

Recent history of unpaid utility bills, rent, etc.(within the past five years): Yes No, If yes, explain: _____

Recent history of Eviction (within past five years): Yes No If yes, explain cause of eviction: _____

History of criminal activity Yes No If yes, explain: _____

Participant's Transition Goals

1. List Goal
2. List Goal
3. List Goal
4. (add more)

Describe Interest/ability for working on Self-management (What will participant be willing/able to do to improve self-management of medical conditions, medications, finances, appointments, physical rehabilitation, alcohol/substance abuse, etc.?) (5000 characters)