MEDICA INSTRUCTIONS FOR COMPLETION OF 
DHS MY MOVE PLAN SUMMARY (E-DOCS DHS 3936)

This plan is for supporting the member to prepare for a move, supporting the member through the move and adjustment after the move, and to creating a summary of key information to facilitate a successful move and transfer of supports and services.

Who does this affect?
- EW (Elderly Waiver) Members only

When should a Transition Plan be completed?
- If the person indicates on LTCC (Long Term Care Consultation) E.12 No
  And
- If the person indicates on LTCC E.13 Prefer to live somewhere else or don’t know
  And
- If the person indicates on LTCC 13a. That they would like help to look at other affordable places to live

A member that knows what they want and has the skills to put it together with minimal planning has the right to opt out of extensive planning and follow-up. If the My Move Plan Summary is not completed, documentation to indicate why My Move Plan Summary was not completed must be present in case notes

The following must be attached to the My Move Plan Summary:
- Person’s Medication Schedule
- Person’s back-up or crisis plan (what the person will do in emergencies, such as failure of service provider to show up on schedule, unexpected loss of provider, or mental health crisis)

Additional Care Coordinator Contact Requirements:
- Care Coordinator is responsible for ensuring communication in person-centered way and timely manner is occurring between everyone involved in the person’s paid and unpaid supports.
- All moves (whether short term changes or long term changes) need to be monitored to determine if a new My Move Plan Summary or changes in the My Move Plan Summary are warranted.
- For emergency transitions where there is isn’t time for planning, the Care Coordinator must go back to the My Move Plan Summary once the crisis stabilizes and ensure that the plan for the member supports his or her individual goals and quality of life.
- Care Coordinator documentation should include coordination between those doing the planning and those providing supports and services to ensure that the My Move Plan Summary results is person-centered services.
- Care Coordinator documentation should include all contacts regarding My Move Plan Summary.
Initial Contact (Essential supports vs. Non-Essential Support requirements differ)

- **Day of move** - In cases where it is essential that supports, services, necessary medication, and medical care are in place from day one, there **MUST** be contact by either the Care Coordinator or the individual listed in the “my follow-up support” section of the *My Move Plan Summary* on the day of the move to ensure those are in place including:
  - Supports, services, medications, and equipment are in place
  - Service providers know any relevant parts of the plan (e.g. what makes a good day/bad day, how the person wants services delivered, positive supports plan, crisis plan)
  - The person has and understands his or her crisis/back-up plans

- If the move is planned to occur at a time when the Care Coordinator may not be available (i.e.: weekends or after hours) and essential supports, services, etc. are needed from day 1, the Care Coordinator should discuss with the “follow-up support” individual how to respond if essential supports, services, necessary medication and medical care needs are not in place.

- **First Week** - If there are no essential supports, services, necessary medication, immediate medical care, the Care Coordinator or the individual listed as “my follow-up support” section of the *My Move Plan Summary* is expected to complete follow-up with the person within a week of the move.

Follow-Up Contact

- **Contact within first 45 days** - The Care Coordinator will compare the new situation to the plan and address any identified ongoing gaps or problems.
  - Is the person living where he or she want to be?
  - Is his or her house stable?
  - Is the person’s budget/funds sufficiently covering the necessary costs?
  - Is the person receiving the types of services, in the way specified, in the plan?
  - Is the person able to pursue his or her own interests (see the people he or she wants to see, go the places he or she wants to go, eat his or her desired foods, have his or her home the way the person wants it, pursue employment opportunities as desired, etc.)
  - Are the professionals in the person’s life continuing to work toward the goals identified in the transition plan?
  - If there are barriers to achieving the goals are they being addressed?

- **Ongoing review** - Determined on case-by-case basis, following person-centered principles of “important to” and “important for” included in the plan. The person who has moved and the person doing the follow-up will assess the stability of the person, identify risks and develop a plan to increase stability.

- **Emergency/unplanned incidents** - (e.g., emergency room visits, hospitalizations, police calls, crisis calls) or the person is at risk the Care Coordinator will work with the person to create a plan that is person-centered for achieving stability, or ensuring another part is doing so.
# I. Case Manager/Support Planner Responsibilities

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<thead>
<tr>
<th>Element</th>
<th>Options</th>
<th>Rationale</th>
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| If the *My Move Plan Summary* was not completed, the Care Coordinator should indicate why | a. Care Coordinator was not aware of move  
b. Person declined to complete move plan summary  
c. Other | b. A member that knows what they want and has the skills to put it together with minimal planning has the right to opt out of extensive planning and follow-up.  
c. Must document other reasoning |

# II. My Information

| Member name *(required)* | First Name, Middle Initial, Last Name |

# III. My Goals

| The place I want to live is | Home, smaller home or apartment, relatives home (specify), board and lodge, boarding care facility, nursing home, other (specify), don’t know |
| The address I’m moving to *(required)* | Street Address, City, State, Zip Code, Move Date |
| These are the important things I want the people who support me to know | Enter information and preferences the member identifies as important to them. (i.e., their culture, beliefs, dignity, living close to family, visiting friends, attending church). |
| These are the people who are important to me | Name, Relationship to person, Contact information. This may be person’s family and/or legal representative, and any others chosen by the person |

# IV. My Supports

| This is how I will get to my new place and this is the person(s) who will take me there *(required)* | Name, phone number of person(s) providing transportation  
This may be a friend, family member, agency, or transportation company |
| This is what I need to set up my new place *(required)* | May include transitional services provided thru EW or Moving Home MN (Lease and rental deposits, essential furniture, utility set up fees and deposits, basic house hold items, personal items, window coverings), Or services under other waivers (Chore Services, Homemaker, Home modifications and adaptations, Equipment and supplies) |
| The person(s) who will help me with this *(required)* | Name, phone number of person(s) |
| This is where my belongings are now | Street Address, City, State, Zip Code |
| Date and time my belongings will arrive | Date and Time (best practice would be to have |
This is how my belongings will get to my new place *(required)*

| Name, phone number of person(s) providing transportation
| This may be a friend, family member, agency, or moving company |

This person will deliver my belongings *(required)*

| Name, phone number of person(s) |

This is who I will call if my belongings don’t arrive *(required)*

| Name, phone number of person(s) |

If I take medications, this is who will help me make sure my medications get to my new place and who will help me get them organized *(required)*

| Name, phone number of person(s) |

Pharmacy information

| Name, address, phone number |

V. My Follow-Up Supports

| Date and time someone will check with me to see if I’m OK after I get to my new place *(required)* | Date and Time |
| This is who will check in with me as I settle in my new place *(required)* | Name of person(s) |
| This is how I contact this person if I need something *(required)* | Type of contact (in person, telephonic, email) contact information |
| I have upcoming appointments *(required)* | Yes or no, if yes |
| These people are my support team *(required)* | Name of person(s) |

VI. My Move Plan Summary

| My full plan is kept in this location | Location where individual will keep My Move Plan Summary |
| These are the other people who have a copy of my plan | Name of person(s) |

VII. Signatures

- If the *My Move Plan Summary* was completed via face to face meeting, all people responsible for implementing the plan, including, but not limited to, the support team involved in planning should sign the *My Move Plan Summary* to indicate they have received it, understand the responsibilities, and their agreement to implement the plan.
- If the planning happened over the phone, check the box that indicates planning session happened over the phone (and therefore will not have my signature)

This plan is considered a living document, it is not expected that everything is finalized immediately; the Care Coordinator will need to adjust and modify the plan as changes occur.

Once My Move Plan is finalized & completed, the My Move Plan and required attachments should be stored in the members’ case file and are subject to Medica review.