

Transition Plan

Customer Name: _____ SS# _____ DOB: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Address: _____ Phone #: _____

Summary of medical problems, allergies and medications:

Impairment in Activities of Daily Living/Important Areas of Life Functioning:

Medical Health Care Provider: _____ Phone #: _____

Mental Health Care Provider: _____ Phone #: _____

Drug Treatment Provider: _____ Phone #: _____

Weekly Schedule (substance abuse treatment, mental health treatment, medical care, vocational/educational, employment, etc):

Financial Plan:

Monthly Income Amount: _____ Type of Income: _____

Amount Saved/Available: _____

TRANSITION PLAN: (What community resources have you and the customer discussed; which community resources has the customer already connected with that will aid the customer following transition from your shelter; what is the housing plan for the customer once discharged from the facility?)

Shelter Manager or Designee

Date