Transitional Living & Planning Application

TLP providers are independent living settings with staff on site from 8-16 hours per day.

Restart and TLP settings require a one-time non-refundable program fee equal to 30% of the member's adjusted income that is due upon intake. Please note, TLP settings cannot accommodate members in wheelchairs who cannot transfer to another assistive device, such as a walker.
Does Member have Income: Select Yes or No. **If Yes, Amount and Source:** Click here to enter text.

Please submit a social security income verification letter with this application (if applicable), if the member does not have income a No Income Form is needed.

*** This application is good for a 30-day period. A new application will be required if 30-days have passed, or circumstances have changed.**
Please complete this form electronically and email to: TLP@mercycareaz.org

Background Information:
Member Name: Click here to enter text. **Gender:** Choose an item. **DOB:** Click here to enter text.

AHCCCS ID: Click here to enter text. **AHCCCS T19:** Select Yes or No. **SMI Status:** Select Yes or No.

Does member have a Social Security Card: Select Yes or No.

Does member have a State ID: Select Yes or No. **Does member have a Birth Certificate:** Select Yes or No.

COT: Select Yes or No. **PNO:** Click here to enter text. **Clinic:** Click here to enter text. **ACT:** Select Yes or No.

Does member have a Guardian: Select Yes or No. **If Yes, Name and Contact Information:** Click here to enter text.

Does Member require an Advocate: Select Yes or No. **If Yes, Name and Contact Information:** Click here to enter text.

Clinical Director: Click here to enter text. **Clinical Director Email:** Click here to enter text.

Clinical Coordinator: Click here to enter text. **Clinical Coordinator Email:** Click here to enter text.

Case Manager: Click here to enter text. **Case Manager Email:** Click here to enter text.

Discharge Planner: Click here to enter text. **Discharge Planner Email:** Click here to enter text.

Primary Care Provider: Click here to enter text.**Phone & Fax Number:** Click here to enter text.

Member's Current Location: Click here to enter text. **Member's Prior Living Arrangement:** Click here to enter text.

Does member have any Felony Charges: Select Yes or No. **If Yes, Please Specify:** Click here to enter text.

Does member have Parole/Probation Officer: Select Yes or No. **If Yes, Name and Contact Information:** Click here to enter text.

Is member a current sex offender: Select Yes or No.

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Treatment Goals

Is Member Able To Do The Following:

Does Member require staff assistance for overnight hours? Select Yes or No.
If Yes, member is not appropriate for TLP.

Can Member take medications independently without observations? Select Yes or No.
If No, member is not appropriate for TLP.

Does member have a history of violence, aggression, or destruction of property? Select Yes or No.

Does member have a history of arson? Select Yes or No.

Does member have an eviction or been asked to leave a program due to inability to maintain a hygienic environment? Select Yes or No.

Dress Independently? Select Yes or No. **Bathe Independently?** Select Yes or No.

Cook Simple Meals? Select Yes or No. **Clean Personal Living Space?** Select Yes or No.

Able to Stand Independently? Select Yes or No.
If No, What Type of Assistance is Needed: Click here to enter text.

Does member have a service animal? Select Yes or No.

Please note that emotional support animals are NOT accepted at TLP.

Manage Finances? Select Yes or No.
Payee Information, if Applicable: Click here to enter text.

Able to Walk Independently? Select Yes or No.
If No, What Type of Assistance is Needed: Click here to enter text.

Shop for Food/Personal Needs? Select Yes or No.

Use Public Transit? Select Yes or No.

Schedule and take Cab or Veyo to a Specific Location? Select Yes or No.

Is Member able to communicate in English? Select Yes or No.

If not, what is Member's Primary Language? Click here to enter text.

Is the Member Currently Prescribed Methadone? Select Yes or No.
If Yes, do they have an outpatient provider, please include contact information? Click here to enter text.

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IMPORTANT: This is a 30-day transitional program. One of the transition plans developed with the member should be achievable within 30-days. Members who will not agree to at least 2 transition plans are NOT eligible for a TLP referral. TLP CANNOT be a transition plan. Please note, Respite and Hotels/Motels are NOT transition plans.

***Transition Planning*: (only 1 option needed for Plan A)**

Plan A (RBHA Funded/Offered Services)
Does the Member Require Treatment? Select Yes or No.

Has an Application Been Submitted to FlexCare@mercymaricopa.org: Select Yes or No.

Date Submitted: Click here to enter text.

Plan A (Non-RBHA Funded/Offered Services)

Does the Member Need Housing? Select Yes or No. **If Yes, Please Specify Type:** Choose an item.

Has an application been submitted to ABC/Hom Inc.: Select Yes or No.
Date Submitted: Click here to enter text.

Has an application been submitted to Estrella de Vida.: Select Yes or No.
Date Submitted: Click here to enter text.

Plan A (Non-RBHA Funded/Offered Services)
Other, please Specify (Might be another option from Plan B) Click here to enter text.

Plan B
Community Housing Resource Option? Click here to enter text.
Possible Community Housing Resources Might Include, but are Not Limited to the Following:
Section 8 (city specific)
Independent Living (own or shared apartment, condo, bedroom in home)
Living with Family/Friends
Sober Living
Halfway Houses

Does the Member Have or Will Have In Near Future (30 days) a Housing Voucher? Select Yes or No.
If Yes, has a Permanent Supportive Housing (PSH) Community Building Provider been Selected? Select Yes or No.
If Yes, which provider has been selected? Click here to enter text.

Member Name: Click here to enter text. **Signature:**______________________________ **Date:** ______________

Clinical Coordinator Name: Click here to enter text. **Signature:**_________________________ **Date:** ____________

Clinical Director Name: Click here to enter text. **Signature:** ___________________________ **Date:** ______________