**CONTRACT**
**NURSING FACILITY TRANSITION PROGRAM**

**I,_____understand that I am participating in the Nursing Facility Transition Grant Program.**

**In receiving services, I will participate in developing an independent living plan. The plan will include my goals and choices, an independent living evaluation and other pertinent information. Furthermore, I will work in partnership with my care coordinator and other support circle members to achieve my goals in the manner and time agreed upon by the care coordinator and myself. Anytime I choose to end this relationship, I may do so by notifying the care coordinator of my decision in writing or in an alternative format.**

**I understand that the care coordinator, the Project Coordinator, and other support circle members are not themselves making medical decisions or making decisions about the transition process for me. The care coordinator, Project Coordinator, and other support circle members are not responsible for any consequences to my health resulting from a transition to community-based care and/or a residential setting.**

**The options and risks of transitioning to the community have been explained to me.**

**Furthermore, I understand that the care coordinator is obligated in aiding the transition from the initial planning stage through the actual transition and follow up as long as I am eligible for waiver services.**

**I authorize the care coordinator,_____, to share information that is reasonably necessary to assist me in achieving my goals with members of the transition team. I can revoke this consent at any time.**

**Consumer signature_____Date_____**

**Witness signature_____Date_____**

**Family member or support circle member_____Date_____**