|  |  |
| --- | --- |
| **SECTION 1.** | **CONTACT INFORMATION**  |
| **DATE** | Click here to enter a date. |
| **INDIVIDUAL NAME** | Click here to enter text. |
| **INDIVIDUAL DOB** | Click here to enter text. |
| **INDIVIDUAL MEDICAID #** | Click here to enter text. |
| **CSB** | Click here to enter text. |
| **PROVIDER NAME** | Click here to enter text. |
| **PROVIDER MAILING ADDRESS** | Click here to enter text.Click here to enter text. |
| **LOCATION OF HOME** | Click here to enter text.Click here to enter text. |
| **PROVIDER POINT OF CONTACT** | Click here to enter text. |
| **PROVIDER PHONE NUMBER** | Click here to enter text. |
| **PROVIDER EMAIL** | Click here to enter text. |
| **TRAINING CENTER/STATE FACILITY**  | Click here to enter text. |
| **HOW MANY BEDS IS THE HOME LICENSED FOR?** | Click here to enter text. |
| **SECTION 2.** | **SUMMARY OF INDIVIDUAL SUPPORT NEEDS** |
| **Please list the essential support needs documented in the Discharge Plan and Discussion Record, for which Transitional Funding is requested.**  | Click here to enter text. |
| **SECTION 3.**  | **CATEGORIES: Describe the request for funding within each category. Complete only the categories under which Transitional Funds are requested** |
| **ENVIRONMENTAL****MODIFICATIONS**  | Click here to enter text. |
| **EQUIPMENT** | Click here to enter text. |
| **VEHICLE MODIFICATIONS**  | Click here to enter text. |
| **ADDITIONAL STAFF TRAINING**  | Click here to enter text. |
| **OFF-SITE SUPERVISION** | Click here to enter text. |
| **NUTRITIONAL SUPPLEMENTS** | Click here to enter text. |
| **EMPLOYMENT SERVICES** | Click here to enter text. |
| **MISCELLANEOUS** | Click here to enter text. |
| **Section 4.** | **fUNDING rEQUESTED**  |
|

|  |  |  |  |
| --- | --- | --- | --- |
| **Funding category** | **Description**  | **Rate** | **total** |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **TOTAL REQUESTED:** $TOTAL |

 |
| **SECTION 5.**  | **TIME LINE (Complete this section based on discharge planning goals)** |
| **ASSESSMENT** | Click here to enter a date. |
| **INITIAL PROVIDER MEETING** | Click here to enter a date. |
| **DAY VISIT**  | Click here to enter a date. |
| **EVENING VISIT**  | Click here to enter a date. |
| **OVERNIGHT VISIT**  | Click here to enter a date. |
| **FINAL PROVIDER MEETING**  | Click here to enter a date. |
| **NEW STAFF HIRE**  | Click here to enter a date. |
| **ENVIRONMENTAL MODIFICATIONS**  | Click here to enter a date. |
| **LICENSING** | Click here to enter a date. |
| **DISCHARGE DATE** | Click here to enter a date. |
| **SECTION 6.**  | **SIGNATURES (Only original signatures permitted)** |
| The following documentation is required with application submission. For assistance obtaining this information, please contact the training center Community Integration Manager:  * Discharge Plan and Discussion Record
* Quotes for Home Modifications, equipment, and vehicle modifications
* Copy of proposed monthly activities if applying for Employment Services.

 **This application is submitted by the parties below. All signatures MUST be original. No scanned/copied signatures accepted.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Provider/Title Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Received by Date Received |
| **SECTION 7.**  | **AGREEMENT/FUNDING APPROVED**  |
| * This Transitional Funding Agreement is entered into by and between the Department of Behavioral Health and Developmental Services (“DBHDS”), and Click here to enter provider name..
* WHEREAS Virginia approved limited funding as a part of the plan to support individuals transitioning from Training Centers back to the community, according to the “Community Move Process;” and
* WHEREAS Transitional Funds support the planning and move of these individuals to their own homes or to a provider home licensed by the DBHDS; and
* WHEREAS DBHDS received a Transitional Funding Application for the individual named herein and DBHDS has approved Transitional Funding as specified herein.
* NOW, THEREFORE, in consideration of the agreements contained herein, DBHDS and Provider agree as follows:

**1. ITEMS FOR WHICH TRANSITIONAL FUNDING IS PROVIDED.**  In accordance with DBHDS Transitional Funding Guidelines and the Application, DBHDS has approved Transitional Funding for Click here to enter individual name.. Transitional Funding is approved for the following goods and/or services in the following amounts:

|  |  |  |  |
| --- | --- | --- | --- |
| **Funding category** | **Description**  | **Rate** | **total** |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Choose an item.** | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **TOTAL REQUESTED:** $TOTAL |

**2. PROVISION OF TRANSITIONAL FUNDING.** Approved Transitional Funds will be distributed to reimburse Provider following the provision of services. Once the individual has been discharged, Provider shall send proof of expenditures to the DBHDS by the 15th day of each month in which reimbursement is being requested.  **2.1 Invoices.** Invoices will be approved once all signatures have been received and a transitional funding agreement has been entered into. Providers have 1 year from the date of application submission to use approved funds. **3. PROVIDER OBLIGATIONS.**   **3.1.** Provider shall support the individual for a minimum of twelve (12) months unless the individual chooses to receive services from another provider or Provider becomes unable to meet the individual’s needs. Provider must utilize all available interventions and technical assistance resources provided by DBHDS before recommending that the individual locate to another residence. **3.2.** Provider shall use Transitional Funds only as specified in Section 4 of this Agreement. Provider shall comply with all requests by DBHDS for information and documents related to the provision and use of goods and services for which Transitional Funding has been provided.  **3.3** In the event that the individual is relocated, all adaptive equipment purchased specifically for the individual using Transitional Funds shall accompany him or her to the next residence.**4. RIGHT TO RECOVER TRANSITIONAL FUNDING.** If Provider is not able to fulfill its commitment to support the individual for a minimum of twelve (12) months, DBHDS may request return of and recoup all Transitional Funds used for any home or vehicle modifications. However, if the individual or his AR chooses to receive services from another provider or if the provider will make the home/vehicle modifications funded with Transitional Funds available to another individual exiting a training center and the provider has addressed, through approved corrective action, any citations of violations of the *Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-105, and the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services*, 12 VAC 35-115, DBHDS will not seek recovery of the Transitional Funds provided for those modifications. In the event that an individual is relocated, all adaptive equipment purchased specifically for the individual using Transitional Funds shall accompany him/her to the next residence.**5. MODIFICATION.** Modifications to the amount or frequency of a good or service for which Transitional Funds are approved herein may be approved in writing at the sole discretion of DBHDS. No modifications to this Transitional Funding Agreement shall be permitted to change or substitute the type of good or service provided. In that event, a new application shall be submitted. IN WITNESS WHEREOF, Provider and DBHDS have executed this Agreement as of the date of the latest signature.**PROVIDER:**Name: Click here to enter text.Title: Click here to enter text.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DEPARTMENT OF BEHAVIORAL HEALTH AND****DEVELOPMENTAL SERVICES:**Name: Title: Assistant Commissioner or DesigneeSignature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\*\*Funds must be invoiced within 12 months of the latest signature noted above.\*\***  |