State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Nursing Facility Transition Grant Application

The Nursing Facility Transition (NFT) program provides individuals currently in a nursing facility with the opportunity to return to community based living. This may be the individual's own home or apartment or the home/apartment of family or friends. NFT may also help with finding housing or a supportive living environment.

Program Eligibility:

- 18 and over;
- Resides in a nursing facility or LTC facility for over 60 days;
- Desires to live in a setting outside of a nursing or LTC facility;
- Has identified a barrier to moving home;
- Needs assistance with ADL's or IADL's

Transition process:

- The individual, social worker, or friend request to develop a Nursing Facility Transition plan in order to move home;
- The Nursing Home or LTC facility assists the individual in developing a transition plan, assists with completing the NFT Application, and submits to local Center for Independent Living (CIL);
- The CIL reviews the application and ensures there is a transition plan in place. If there is no transition plan, the CIL will work with the individual to develop a plan for moving home and shares the plan with the individual and nursing home or LTC facility.
- The CIL NFT program makes purchases and assists the individual with accessing other home and community based services if needed.
- Individual moves home!

Initiating Service

Have your Care Coordinator/Case Manager contact the local Center for Independent Living (CIL):

- Kenai Peninsula Independent Living Center 1-800-770-7911 (toll-free)
- Access Alaska, (Anchorage, Mat-Su Western Alaska) 1-800-770-4488 (toll-free)
- Access Alaska, (Fairbanks, Interior, Northern Regions) 1-800-770-7940 (toll-free)
- S.A.I.L. Southeast Alaska ILC 1-800-478-7245 (toll-free)
- Arctic Access, Kotzebue, Nome 1-877-442-2393 (toll-free)

Nursing Facility Transition Grant Application

Recipient Information

Recipient name: Medicaid #:

Date of Birth: Gender: Male Female

Race: Current Health Care Coverage:

Recipient Representative:

Representative Name: Address:

City/State/Zip: Contact Number:

Person Completing Form:

Current Nursing Facility/Hospital

Name of Facility: Physical Address:

City/State/Zip: Discharge Date:

Discharge Planner: Length of Time in facility:

Discharge Contact: Admission Date:

Transitioning to:

Physical address: City/State/Zip:

Mailing address same? Yes No, Please complete mailing address below.

Mailing address: City/State/Zip:

Telephone/cell: Email address:

Individual Needs Assistance with the following:

Activities of Daily Living (ADLs)	Check for Yes	Instrumental Activities of daily living (IADLs)	Check for Yes
Bed Mobility		Meal Preparation	
Transfers		Shopping	
Locomotion		House Keeping	
Eating		Laundry	
Toileting		Medication Assistance	
Personal Hygiene		Other Chores	
Bathing			
Dressing			

Identify Barriers to a successful transition:

Has a transition plan been developed to support the individual & attached? Yes No

Center for Independent Living

CIL representative: CIL:

Contact Phone: Email:

Would the individual benefit from a prescreen? Yes No Date of Prescreen:

Total Amount Requested: $

Items requested	Amount	Vendor

I certify that the information submitted in this form is true and accurate to the best of my knowledge. It is my understanding that the items or services for which I have requested this grant are not covered by any other funding source.

Applicant Signature: Date:

Signature of Legal Guardian: Date:

Approved Denied	Approved Amount: $	Date:

NFTG/CIL Staff Signature:	Title:

Comments:

LTC-03
New 3/7/2017
ADA 1/2/2020