Transition Services Form (TSF)

Waiver Type: ADHC ☐ CCW ☐

OAAS Regional Office (R.O.): _____

Participant's Name: _____ SSN:

PROJECTED Move Date: _____

ACTUAL Move Date: _____ Final Approved TSF Date: _____

Nursing Facility Name: _____

Total Estimated Cost: _____ Total Actual Cost: _____

ITEMIZED TSEPA EXPENSES

Area	Item	Designated Purchaser's Initials	Number of Items Requested	Estimated Cost	Actual Cost (based on purchase receipt)
Deposits/Fees	Security Deposit (House)				
	Security Deposit (Apartment)				
	Telephone Deposit				
	Electric Deposit				
	Gas Deposit				
	Water Deposit				
Living Room	Sofa/Love Seat				
	Chair				
	Coffee Table				
	End Table				
	Recliner				
Dining Room	Dining Table/Chairs				
Bedroom	Bedroom Set				
	Mattress/Box Springs				
	Bed frame				
	Chest of Drawers				
	Nightstand				
	Comforter				
	Sheets				
	Pillows				
	Lamp				
	Telephone				
	Refigerator				
	Stove				
	Cooktop				
	Dishwasher				

Kitchen	Convection Oven				
	Dishes/Plates				
	Glassware				
	Cutlery/Flatware				
	Microwave				
	Coffee Maker				
	Toaster				
	Crock Pot				
	Indoor Grill				
	Pots/Pans				
	Drain board				
	Storage Containers				
	Blender				
	Can Opener				
	Food Processor				
	Mixer				
	Dishcloths, Towels, Potholders				
Bathroom	Towels				
	Hamper				
	Shower Curtain				
	Bath Mat				
Miscellaneous	Curtain Rod				
	Washer				
	Dryer				
	Vacuum Cleaner				
	Air Conditioner				
	Fan				
	Broom				
	Mop				
	Bucket				
	Iron				
	Ironing Board				
Moving Expenses	Moving Company				
	Cleaners (prior to move; one time expense)				
Health and Welfare	Pest Control/Eradication				
	Fire Extinguisher				
	Smoke Detector				
	First Aid Supplies/Kit				
Total Estimated Cost					
Total Actual Cost					

Pre-Approval Authorization

Pre-Approved Authorization Amount: _____

SC Signature: _____

Date: _____

SC Supervisor Signature: _____

Date: _____

Support Coordination (SC) Agency Information:		
Name:		
Agency:		
Address:		
Telephone Number(s):		
E-Mail Address:		
SC Signature:		Date:

Designated Purchaser (DP) Information:		
Name:		
Agency:		
Address:		
Telephone Number(s):		
E-Mail Address:		
DP Signature:		Date:

Designated Purchaser (DP) Information:		
Name:		
Agency:		
Address:		
Telephone Number(s):		
E-Mail Address:		
DP Signature:		Date:

Designated Purchaser (DP) Information:		
Name:		
Agency:		
Address:		
Telephone Number(s):		
E-Mail Address:		
DP Signature:		Date:

To Be Completed by SC Supervisor for FINAL APPROVAL:

This will verify that SC Supervisor has reviewed the TSF for completeness and compliance and verified receipts for actual expenditures.

Participant's Name: _____ SSN: _____

APPROVED: ☐

Total Actual Cost: _____ NOT APPROVED: ☐

SC Supervisor Signature: _____ Date: _____