TRANSITION PLAN

Designed For: _____*(Name)*

on _____

(Date of Transition Meeting)

(Picture of person here)

This Transition Plan has been developed

to Facilitate the Continuity of Services during

the transition from _____

to ***(home address)***_____

at ***(agency name)***_____

The purpose of this meeting is to develop a Transition Plan for (Name)_____ , DHS ID#_____ to move from _____ to _____.
The parties agree that the plan formulated on this date is mutually agreed to and the new agency is able to provide the services.

I. Transition Plan Participants	**Signatures**
Individual	
Parent and/or Guardian	
Qualified Support Professional (QSP), Chairperson	
Nurse	
Social Service Representative	
Living Area Administrative Staff	
Living Area Direct Service Staff	
Physician	
Psychologist	
Developmental Training/Work Staff	
ISC/PAS	
New Residence Staff	
Other Participants:	

II. Identifying Information

A) Name: ____ Date of Birth: _____ DHS ID#: ____

B) Diagnosis:

C) General physical description of the individual:

D) Guardianship Information:
Competent Yes____ No____ (If no, complete the following)
Name of Guardian(s):
Relationship to person:
Address:
Phone Number: Email address:
Type of Guardianship: Person____ Estate____ Plenary ____ Limited____ (describe limits below)

Any changes in guardianship status recommended? Yes___ No___ (If yes, specify and describe plan to address guardianship changes:

List any pre-paid burial arrangements or burial wishes:

E) Risk Identification for health, safety and welfare of individual (identify current and historical risks):

Known Risk	Intervention	See page ___ of
Known Risk	Intervention	See page ___ of
Known Risk	Intervention	See page ___ of
Known Risk	Intervention	See page ___ of
Known Risk	Intervention	See page ___ of
Known Risk	Intervention	See page ___ of

III. Individual, Family/Guardian and Agency Considerations

A) INDIVIDUAL CONSIDERATIONS

1) Explain the individual's involvement in the transition process and orientation to the new residence:

2) Personal Preferences (likes/dislikes, preferred routine, normal weekly spending, environmental preferences)

3) Address family relationships, friendships, intimate relationships, social roles or volunteer activities that might be affected by the move and supports provided by (name of SODC and/or Agency) necessary to ensure a smooth transition maintain these relationships:

4) Specify the major gains achieved during the past few years:

5) Document any concerns/issues communicated by the individual regarding this move and how these issues/concerns have been, or will be addressed and by whom.

6) In a brief narrative of the transition history, include the following information: date goal was first identified and preferences specified at the time in terms of geographic location, type of residence and house/roommate preferences.

7) In addition to the programs and services that were provided, the individual/guardian were exposed to a variety of experiences in order to assist them in making an informed choice about where and with whom to live. These experiences are summarized below.

Name of organization:
Dates and types of contacts (Describe screening, visits with person at their home, visits with person/guardian at the prospective agency)

Response of person/guardian:

Name of organization:
Dates and types of contacts (Describe screening, visits with person at their home, visits with person/guardian at the prospective agency)

Response of person/guardian:

Name of organization:
Dates and types of contact(s) (Describe screening, visits with person at their home, visits with person/guardian at the prospective agency)

Response of person/guardian:

8) Describe previous transitions to other residences, what transpired to end that placement, and what steps have been taken to prepare the person for this current move. Include length of previous placements at specific residences with appropriate time increments (e.g., days, months or years).

9) Identify any potential issues that might occur after he/she moves to his/her new home which may be indicative of his/her adjustment process (e.g. the person paces when meeting new people, the person's rate of speech may become fast paced, the person may display an excessive amount of body rocking; SIB may surface in the form of)

B. FAMILY/GUARDIAN CONSIDERATIONS

10) Explain the family/guardian's involvement in the transition planning process.

11) Document any concerns/issues communicated by the family/guardian regarding this transition. Document how these issues/concerns have been or will be addressed, and by whom.

12) Describe guardian's desire for information regarding day to day events, their level of involvement in day to day or special events, and frequency of visits, mail, phone calls, etc.

13) Describe guardian's desire for communication of and/or involvement with medical appointments and notification of injuries.

C. AGENCY CONSIDERATIONS

1) Agency name and address of new home

2) Agency contact person (name, title, and phone number)

3) Description of services and staff resources (inclusive of staff on duty, ratios per shift and professional supports)

4) If subsequent staff add-on support is anticipated, the agency needs to begin documenting the needs of the individual to justify their request. Possible concerns include:

IV. Services, Supports, Strengths, Abilities, Needs, Preferences & Programs

A) Current strengths, abilities, needs and preferences are documented in the Individual Support Plan dated: _____ .The Individual Support Plan, the Special Team Meetings conducted subsequent to this plan, Monthly Reviews, the Individual Schedule and the Rights Review provide the major framework for the decisions rendered in this section along with relevant assessments and consultations. These materials were provided to the agency on _____ (specific date).

B) Based on team review of the current assessments, including the Clinical Transition Plan, the following services, supports, programs, needs and preferences recommended for continuation at the new residence and/or developmental training/vocational program/school/work location are as follows:

Current Services, Supports, and Programs	**Supports and Services to be Provided by Community Agency**
Personal Goals	Agency plan to address personal goals: Responsible person:

Skill Programs:	Agency plan to address skill programs:
Supervision: List current level of supervision and stipulations.	List proposed level of supervision and stipulations.
Medical and Nursing: **See Clinical Transition Plan** SODC Physician: Phone # SODC Primary Nurse Phone#	Physician services to be provided by: Date of first appointment: Hospital services to be provided by:
Pharmacy: Note: If he/she is prescribed Depakote ER, obtain prior approval for its continued prescription in the community (if person receives Medicaid).	Medication and amount to be provided upon discharge: Responsible person:

Psychotropic Medication Plan for psychotropic and other targeted behavior medication including increases or decreases: Date of last increase/reduction:	Agency plan to follow-up on psychotropic and other behavior targeted medication: Responsible person:
Psychiatric: **See Clinical Transition Plan** Current Psychiatric services are provided by:	Agency plan to follow-up on psychotropic and other behavior targeted medication: Responsible person:
Behavior Intervention: **See BIP for further information** List Target behaviors:	Proposed Behavior Plan: Responsible person:
Counseling (as applicable): Current counseling services are provided by: List informal or formal counseling services:	Counseling services to be provided by: Date of first appointment:
Oral Motor: (dysphagia or similar test results, as applicable):	Date of first evaluation: Responsible person:

Nutritional/Dietary Services: List diet and associated snacks: List food likes/dislikes: List any food allergies:	Date of first evaluation: Responsible person:
Dental: **See Clinical Transition Plan**	Dental services to be provided by: Date of first appointment:
Vision: Current Vision Services provided by: Current Prescription:	Vision Services to be provided by: Date of first appointment:
Hearing Services: Current Hearing Services provided by: Hearing aid used (yes/no, type): Battery type/number:	Hearing Services to be provided by: Date of first appointment:
Communication: Language spoken/understood: List programs, if any: Auditory equipment needed:	Agency plan to provide augmentative equipment: Person responsible:

Vocational: Current work location: Average pay per week: Skills and abilities: Work Preferences: List likes/dislikes:	Day program services by: Proposed work location: Contact name, title, phone number:
Educational: (as applicable) IEP current Home school district:	School district to be contacted:
Occupational Therapy: Minutes of OT needed per day/week:	Occupational Therapy Services will be provided by: Date of first appointment:
Physical Therapy: Minutes of PT needed per day/week:	Physical Therapy Services will be provided by: Date of first appointment:
Inhalation Therapy: **See Clinical Transition Plan**	Inhalation Services to be provided by:

Recreation/Community Access and Integration: (List favorites (shopping, restaurants, community outings, etc.) Transportation needs: Religious preference and place of worship:	Agency's plan for Recreation and Community Access and integration: Transportation will be provided by: Proposed Place of Worship: Responsible person:
Individual Plan Coordination: Current QSP services provided by: Name: Ph# Current QSP's supervisor contact information: Name: Ph# Current PAS/ISC services provided by: Name: Ph# Contact person at SODC: Name: Ph#	QSP services to be provided by: Name: Ph# Current QSP's supervisor contact information: Name: Ph# PAS/ISC services to be provided by: Name: Ph# Contact person at receiving provider: Name: Ph#

Special Consultations: (specify, if not previously discussed): See **Clinical Transition Plan**	Special Consultations: Date of Service: Responsible person:
Exercising Rights - Supports, Limitations, Plans: Communication Financial Affairs Freedom of Movement Personal Property Privacy Informed Refusal of Services Social, Religious, and Community Activities Restrictive Techniques Due Process Freedom from Abuse, Neglect, and Mistreatment	Indicate how supports will be provided to exercise rights: Name of Financial Institution: Indicate date to register to vote at new home (if applicable): Indicate date of first review by HRC committee at new agency (if necessary) Indicate date of first review by BIC committee at new agency (if necessary):

V. Environmental Issues Considered By The Team	
Environmental Issue (list current skills in each area)	**Supports and Services to be Provided**
Use of the Kitchen (stove, refrigerator, silverware, cooking implements, dishes, food items, adjusting hot & cold water, dishwasher, microwave, coffee maker, toaster, other appliances)	
Stairs/Use of Elevator	
Adjusting water temperature for Baths/Showers	
Adjusting water temperature for Hand washing, etc.	
Use of a Basement	
Use of the Yard	
Traffic (ability to cross streets, ride bicycle, etc.)	
Use of Laundry Facilities	
Access to Use of Cleaning supplies; caustic supplies	
Access to & Use of Tools, Gardening, or Lawn Care Equipment	

Access to the Neighborhood	
Access to Locked Areas (use of key(s)	
Access to Electrical Outlets	
Access to Tobacco Products and Lighter Use:	
Access to Medicine Cabinet Supplies/Medications etc.	

VI. Follow-Up Support

A) Identify who will be providing monitoring (specify frequency and the Bureau of Transitional Services contact person and phone number):

C) Identify behaviors which should result in automatic request for assistance from the SODC (specify psychologist's name and work phone number):

D) Name and phone number of staff member who knows the person best to be contacted for assistance in addressing the person's daily routine, communicative expressions of wants and needs, interpersonal interactions, etc. (specify staff name and last work phone number):
Name: Phone #

VII. Services/Action Required Prior To or On Day of Transition

A) Personal Possessions (including adaptive devices)

1) Inventory of personal possessions to be completed by:

2) Plan to move personal possessions (how, by whom and when):

3) Personal possessions to be purchased before the scheduled move (specify items required and who will obtain and target dates by which items are to be procured):

B) Transportation

Specify transportation requirements on the day of the move (type of vehicle, entity providing transportation, staff or other person who will be accompanying the individual and time of day move is planned to occur)

C) Other Services/Actions Needed

Specify other services/actions that are needed and identify the person responsible for ensuring the required action is completed, his/her title or relationship to the individual, and the target date for completion of each service/action item listed)

E) Exit Conference Date and Time:

VIII. Date of Transition

Transition to _____ is scheduled/anticipated to occur on _____.

IX. Signatures

The above information accurately represents the Transition Plan for _____

QSP	**DATE**	**PHYSICIAN**	**DATE**
UNIT DIRECTOR	**DATE**	**CENTER DIRECTOR**	**DATE**

X. Attachments

Attach documents to the Transition Plan not already provided to the new residence, or that has changed since it was provided. Check all that apply.

[ ] Clinical Transition Plan
[ ] Individual Service Plan/Service Objectives
[ ] Behavior Intervention Programs – inclusive of functional analysis (6 months of data)
[ ] Skill Programs
[ ] Medication Side Effects List
[ ] Vocational Assessment
[ ] Other_____
[ ] Other_____
[ ] Other_____