



STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES
DDS218(1)REV. 4/08

TRANSITION PLANNING CHECKLIST

Region: _____

Date: _____

Individual's Name: _____

DDS#: _____

Type of Transition: Residential Day Other _____

A Transition Planning Checklist should be completed for all individuals who are experiencing a major life change such as a change in residence or day setting. The checklist is to be completed by the sending case manager and is intended to be a final check to ensure that actions that will contribute to a successful transition for the individual have been taken.

CHECK **YES** FOR ITEMS THAT REFLECT ACTIONS TAKEN TO ENSURE A SUCCESSFUL TRANSITION FOR THE ABOVE-NAMED INDIVIDUAL AND **NA** FOR ANY ITEMS THAT ARE NOT APPLICABLE:

NA	Yes	<u>INCLUSION & PREPARATION</u>
<input type="checkbox"/>	<input type="checkbox"/>	1. The individual for whom a transition is planned has been involved in the planning process and was formally notified of the change and of his or her rights including the right to appeal.
<input type="checkbox"/>	<input type="checkbox"/>	2. The individual's parents, guardian, and other representatives were formally notified of the planned change, the transition planning meeting, and their rights, including their right to appeal.
<input type="checkbox"/>	<input type="checkbox"/>	3. All possible efforts have been made to secure the involvement of the individual and or her family members or other representatives in the transition planning process.
<input type="checkbox"/>	<input type="checkbox"/>	4. The Medicaid Waiver determination has been made and forms completed
<input type="checkbox"/>	<input type="checkbox"/>	5. Behavior management preliminary planning has been completed by a community behavior management specialist.

NA	Yes	<u>VISITS</u>
<input type="checkbox"/>	<input type="checkbox"/>	6. Support is in place for the continuation of significant relationships in the individual's life. Opportunities to visit with significant others have been planned.
<input type="checkbox"/>	<input type="checkbox"/>	7. The individual has visited the furnished residence in which he or she will live.
<input type="checkbox"/>	<input type="checkbox"/>	8. The individual has visited the worksite or day option he or she will attend.
<input type="checkbox"/>	<input type="checkbox"/>	9. The individual has visited places in the neighborhood where he or she will be living or working such as shops, restaurants, community centers, and churches.

SERVICE ARRANGEMENTS

NA	Yes	<u>Residential Service</u> Planned Residence: _____
<input type="checkbox"/>	<input type="checkbox"/>	10. The individual has met the persons he or she will live with, has similar interests and routines, and seems to be compatible with them.
<input type="checkbox"/>	<input type="checkbox"/>	11. Direct contact persons and other staff needed to support the individual in his or her new residence have been hired and have met with the individual.
<input type="checkbox"/>	<input type="checkbox"/>	12. Direct contact persons in the residence have received training regarding life safety, first aid, CPR, individualized approaches for behavioral support, program issues specific to the individual, and medication concerns.
<input type="checkbox"/>	<input type="checkbox"/>	13. The individual's preferences have been respected in regards to living situation, roommates, room color, and personal household items.

NA	Yes	<u>Day Service</u> Planned Day Service: _____
<input type="checkbox"/>	<input type="checkbox"/>	14. An employment situation or day service has been secured for the individual.

<input type="checkbox"/>	<input type="checkbox"/>	15. The starting date and hours for the daytime activity have been established and transportation to the day setting has been arranged.
<input type="checkbox"/>	<input type="checkbox"/>	16. Staff who will support the individual in the day setting have been hired and have had opportunities to meet with and interact with the individual to be served.
<input type="checkbox"/>	<input type="checkbox"/>	17. Day personnel have been trained regarding life safety, first aid, CPR, program issues, individualized approaches for behavioral support, and medication concerns.
<input type="checkbox"/>	<input type="checkbox"/>	18. The individual has clothing appropriate for the worksite or other day option
<input type="checkbox"/>	<input type="checkbox"/>	19. A referral has been made to BRS.

NA	Yes	<u>Health & Therapy Supports</u>			
<input type="checkbox"/>	<input type="checkbox"/>	20. Specific services and providers have been identified for the individual and the necessary agreements and arrangements are in place:			
NA	Yes	NA	Yes		
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Specialist: _____	<input type="checkbox"/>	<input type="checkbox"/>	General Practitioner: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nurse: _____	<input type="checkbox"/>	<input type="checkbox"/>	Hospital: _____
<input type="checkbox"/>	<input type="checkbox"/>	Dentist: _____	<input type="checkbox"/>	<input type="checkbox"/>	Pharmacist: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ambulance Service: _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychologist: _____ :
<input type="checkbox"/>	<input type="checkbox"/>	Speech: _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatrist: _____
<input type="checkbox"/>	<input type="checkbox"/>	Orthopedist: _____	<input type="checkbox"/>	<input type="checkbox"/>	Podiatrist: _____
<input type="checkbox"/>	<input type="checkbox"/>	Therapist/Counselor: _____	<input type="checkbox"/>	<input type="checkbox"/>	Neurologist: _____
<input type="checkbox"/>	<input type="checkbox"/>	Physical/Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>	Nutritionist: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	21. Arrangements have been made to obtain any needed medical or adaptive equipment.			
<input type="checkbox"/>	<input type="checkbox"/>	22. Emergency back-up plans for behavior response have been developed. Plans specify persons responsible, location of services, and interventions to be used describing the least to most intrusive intervention methods.			
<input type="checkbox"/>	<input type="checkbox"/>	23. If the person receives psychotropic medication:			
<input type="checkbox"/>	<input type="checkbox"/>	a. A behavior treatment plan is in place and approved by PRC.			
<input type="checkbox"/>	<input type="checkbox"/>	b. The person has been screened for signs of involuntary movement disorder.			
<input type="checkbox"/>	<input type="checkbox"/>	c. A psychopharmacological review has been completed.			
<input type="checkbox"/>	<input type="checkbox"/>	24. A neurologist has been identified if the person experiences seizure activity.			

NA	Yes	<u>Community Services</u>			
<input type="checkbox"/>	<input type="checkbox"/>	25. The individual has transportation arrangements to needed services and programs.			
<input type="checkbox"/>	<input type="checkbox"/>	26. Community services and personal supports have been identified and arranged based on the needs and preferences of the individual. Generic services are used when possible:			
<input type="checkbox"/>	<input type="checkbox"/>	a. money management: _____			
<input type="checkbox"/>	<input type="checkbox"/>	b. leisure: _____			
<input type="checkbox"/>	<input type="checkbox"/>	c. adult education: _____			
<input type="checkbox"/>	<input type="checkbox"/>	d. life skill training: _____			
<input type="checkbox"/>	<input type="checkbox"/>	e. social activities/personal associations: _____			
<input type="checkbox"/>	<input type="checkbox"/>	f. religious activity/affiliation: _____			
<input type="checkbox"/>	<input type="checkbox"/>	g. legal services: _____			
<input type="checkbox"/>	<input type="checkbox"/>	h. other: _____			

NA	Yes	<u>FAMILY & ADVOCATE INVOLVEMENT</u>			
<input type="checkbox"/>	<input type="checkbox"/>	27. The individual has access to an advocate during and after the transition.			
<input type="checkbox"/>	<input type="checkbox"/>	28. Family/Guardian support for the transition has been sought. The family has been encouraged to visit the new residence or day setting.			
<input type="checkbox"/>	<input type="checkbox"/>	29. Concerns raised by the individual and the family, guardian, or advocate have been addressed and they have been continually notified of any changes in plans or time frames.			

		<u>PERSONAL ARRANGEMENTS</u>
NA	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	30. The individual's personal possessions have been accounted for and are ready to be transferred with him or her at the time of a move to a new residence or day setting
<input type="checkbox"/>	<input type="checkbox"/>	31. Arrangements have been made for people who are significant to the individual to play an active role on the day of the move.
<input type="checkbox"/>	<input type="checkbox"/>	32. Payment for medical services is in place (e. g., Medicaid card has been applied for).
<input type="checkbox"/>	<input type="checkbox"/>	33. The individual's personal funds have been reviewed and will be transferred to a location close to his or her new home.
<input type="checkbox"/>	<input type="checkbox"/>	34. Responsibility has been determined for handling any SSI, SSA, or state supplement arrangements including reinstating SSI and redetermining SSI payee.

		<u>TRANSITION PLANNING</u>
NA	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	35. A Transition Plan has been established that details the activities that will occur prior to the change in the individual's life and specifies who will carry out each activity.
<input type="checkbox"/>	<input type="checkbox"/>	36. Necessary evaluations of the individual have been completed and shared with the new service providers.
<input type="checkbox"/>	<input type="checkbox"/>	37. Staff from the individual's current home or day setting have participated in the transition planning process and plans for their continued support have been arranged.
<input type="checkbox"/>	<input type="checkbox"/>	38. Key service providers have participated in the development of the transition plan and have received a copy of the plan
<input type="checkbox"/>	<input type="checkbox"/>	39. Staff who will support the individual in his or her new setting have received all necessary and relevant records and information (e. g., the current IP, a personal overview, a personal history and demographic profile; and medical profile).
<input type="checkbox"/>	<input type="checkbox"/>	40. An Individual Plan development meeting has been scheduled for within 30 days of the date of the individual's move.

		<u>OTHER</u>
NA	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	

<u>COMMENTS</u>	

Case Manager Signature: _____

Date: _____