



DDSD Individual Transition Plan

Checklist

This checklist was created to standardize transition procedures for the Developmental Disabilities Waiver, Medically Fragile Waiver, Mi Via Waiver and Supports Waivers. The checklist will be used during transition meetings to facilitate conversations about individual health and safety needs before, during and after transitions. This form must be completed by the current Case Management, Consultant, Community Supports Coordinator or Registered Nurse Case Management agency who facilitates the transition meeting.

Date of form Completion:

Person Completing this form (discharging agency):

Contact information: Email:

Phone Number:

Title of person completing this form (Case Manager/Community Support Coordinator/Consultant Agency/Registered Nurse Case Manager):

Type of Transition:

Individual's Communication Preference (i.e., phone, email, in-person):

Individual Identification Information:

Name:	Date of Birth (DOB):
Social Security Number (SSN):	Phone Number:
Email Address:	Category of Eligibility:
Address:	
MCO:	MCO Care Coordinator:
Current Region/County (if applicable):	New Region/County (if applicable):
Current Waiver (If participant is currently covered under Supports Waiver, please indicate if it is agency based or self-directed):	Date of Transition:
Current Provider:	Receiving Provider:
Contact Person:	Contact Person:
Email:	Email:
Phone number:	Phone number:
Description of the individual's transition situation and any unique or special considerations and/or issues that require further clarification:	

Documents required for successful transition:

***This section identifies any documents that are required to be transferred from the discharging agency to the receiving agency. If documents are not applicable, please indicate with "NA". If documents are required but are not able to be transferred, please provide detailed information on when the receiving agency can expect the documents and who will be responsible for sending the documents to the receiving agency.**

Document(s)	Y/N/NA	Title/Date of Document	Pending or not yet obtained, who will be responsible for obtaining	Date Received	Proposed date of document transfer
Current Year Assessments					
Level of Care (LOC)					
Individual Service Plan (ISP)/Service Support Plan (SSP); attached documents & ISP/SSP & budget revisions					
Current Approval Letter from Income Support Division					
Meeting notes and correspondence as available					

Document(s)	Y/N/N A	Title/Date of Document	Pending or not yet obtained, who will be responsible for obtaining	Date Received	Proposed date of document transfer
Medical Reports/History & Physical and Immunization Record					
List of current medications					
Recent Comprehensive Aspiration Risk Management Plan					
Other evaluations					
Current Individual Education Plan					
Division of Vocational Rehabilitation Plan					
Private Duty Nursing Plan					

Document(s)	Y/N/N A	Title/Date of Document	Pending or not yet obtained, who will be responsible for obtaining	Date Received	Proposed date of document transfer
Allocation Letter/Waiver Change Form(s)/SFOC (for provider changes)					
Guardianship/Power of Attorney Paperwork					
Employer of Record Information form or will an Employer of Record be needed?					
One full year of monthly and quarterly update forms and consultant/Case Management/Comm unity Support Coordinator Agency case notes (narratives) (Previous quarter case notes from Med Frag Registered Nurse Case Manager)					

Document(s)	Y/N/N A	Title/Date of Document	Pending or not yet obtained, who will be responsible for obtaining	Date Received	Proposed date of document transfer
Current Living Care Arrangement					
Copy of personal belongings inventory					
Copy of Assistive Technology inventory					
Family Living Home Study					
Do not Resuscitate (DNR) Do not Intubate (DNI) and advanced directives					
Birth certificate, SS card, Medicaid/Medicare card, ID card					
Other pertinent information					
In-Home Assessment (Vineland)					

***This section facilitates important discussions that help identify any needs that ensure a successful transition. This section is not to replace the ISP/SSP. If discussion questions prompt any action items (i.e., yes answer to discussion questions), details must be included to indicate planned remediation.**

Discussion Questions	Y/N/NA	Discussion details. Identify any follow up if needed and who is responsible for completion and when. If applicable, indicate if ISP/SSP has been updated.	Date of Discussion
Therap Discharge and Transfer needed?			
Are any Assistive Technology, Environmental Modifications or adaptive equipment needs identified?			
Are any Crisis Supports needed?			
Are any trainings needed to support the individual prior to transition?			
Are any eligibility needs identified and planned for? (i.e., Medicaid eligibility)			

Discussion Questions	Y/N/NA	Discussion details. Identify any follow up if needed and who is responsible for completion and when. If applicable, indicate if ISP/SSP has been updated.	Date of Discussion
Is the individual moving to a new home? Indicate if a visit to the new home has been completed.			
Are new housemates identified and planned for?			
Is the transfer for personal belongings planned? Move Date:			
Are any revisions needed for the Individual Support Plan/Service Support Plan and budget? (e.g., new services, goals, etc.)			
Is the participant currently working or wants to work?			
Are there any Regional Office Request for Assistance (RORA) or Abuse Neglect and Exploitation reports pending?			

Discussion Questions	Y/N/NA	Discussion details. Identify any follow up if needed and who is responsible for completion and when. If applicable, indicate if ISP/SSP has been updated.	Date of Discussion
Are there any routine or non-routine schedule/appointments needing follow through?			
Does this transition identify any safety concerns?			
Are there any transportation needs related to the transition? (i.e., Coordination, learning new routes, etc.)			
Are there any concerns with the new service setting following the CMS Final Rule, HCBS Settings Requirements, as applicable?			

Transition Meeting Attendees:

*In this section list all individuals that attended the transition meeting. If the individual identified below is a discharging or receiving provider, please include the signature. Electronic signatures are accepted. If Adobe Acrobat is not available to complete the electronic signature, a wet signature will be accepted. This signature is to confirm all parties have agreed upon the transition meeting, date, and the transfer of records from the previous agency has occurred.

Name	Role	Discharging Agency/ Receiving Agency

Signature for Current Agency

Signature of New Agency

Below, are additional signature lines if transition includes multiple service providers:

Signature for Current Agency

Signature of New Agency

Signature for Current Agency

Signature of New Agency

Signature for Current Agency

Signature of New Agency

Signature for Current Agency

Signature of New Agency

Signature for Current Agency

Signature of New Agency