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|  | **Initial Transition Meeting Discussion Document** |  |
|  | **Assessment Date:** |  |  |
|  | **Plan Date:** |  |  |
|  | **Plan Participants:** |  |  |
|  |  |  |
|  | ***Demographics and Services*** |  |
|  |  |  |
|  | **Individual Information** |  |
|  |  |  |  |  |  |
|  | **Last Name** | **First Name** | **Middle Name** | **DOB** |  |
|  |  |  |  |  |  |
|  | **Phone** | **Street** | **City** | **State** |  |
|  |  |  |  |  |  |
|  | **State ID** | **SSN** | **Medicaid #** | **Medicare #** |  |
|  |  |  |
|  | **Guardian Information** |  |
|  |  |  |  |  |
|  | **Guardian Last Name** | **Guardian First Name** | **Guardianship Type** |  |
|  |  |  |  |  |  |
|  | **Phone** | **Street** | **City** | **State** |  |
|  |  |  |
|  | **Agency Info** |  |
|  |  |  |  |  |  |
|  | **Receiving Agency (Regional Office)** | **POC (Service Coordinator)** | **City** | **Phone** |  |
|  |  |  |  |  |  |
|  | **Transferring Agency (Regional Office)** | **POC (Service Coordinator)** | **City** | **Phone** |  |
|  |  |  |
|  | **Regulatory Compliance** |  |
|  | *To be completed within 30 days* | *See Attached* | *See Attached* | *See Attached* | *To be Completed within 30 Days* |  |
|  | **Annual Personal Plan** | **Choice of Provider / Waiver Choice** | **ICF-MR Level of Care** | **Health Inventory** | **Nursing Review** |  |
|  |  |  |
|  | **Services** |  |
|  | **Service Requested / Identified Provider** | **UR Approved** | **Requested Start Date** | **Authorized Date** |  |
| **YES NO** |
|  |  |  |  |  |  |  |
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| ***Health and Medical*** |  |
| **Current Consulting Professionals** |  |
|  | **Name** | **Type City Phone** |  |
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| **Medical History** |  |
|  |  | Anemia |  |  |  | Measles | Tuber culosis |  |
|  |  | Bleeding/Clotting Disorder |  |  |  | Mumps | Oxygen Use |  |
|  |  | Blood Clots |  |  |  | STD’s | Whee zing |  |
|  |  | Blood Sugar Disorder |  |  |  | Arthritis | Pneumonia |  |
|  |  | Diabetes |  |  |  | Broken Bones | Other Respiratory Disorder |  |
|  |  | High Cholesterol |  |  |  | Chronic Pain | Ear, Nose, Throat Trouble |  |
|  |  | Breast Cancer |  |  |  | Paralysis Eye Disorder |  |
|  |  | Skin Cancer |  |  |  | Osteoporosis | Glauc oma |  |
|  |  | Colon Cancer | Decubitus Ulcer/Skin Breakdown Head | hes |  |
|  |  | Other Cancer |  |  |  | Frequent or painful urination | Heari | Loss |  |
|  |  | Heart Attack |  |  |  | Difficulty Urinating | Vision Loss |  |
|  |  | Dizziness |  |  |  | Gall Bladder problems Seizures or Epilepsy |  |
|  |  | Fainting Spells |  |  |  | Hemorrhoids Stroke |  |
|  |  | Heart Disease |  |  |  | Hernia | Alcoholism |  |
|  |  | Heart Murmur |  |  |  | Kidney Problems | Substance Abuse |  |
|  |  | High Blood Pressure |  |  |  | Liver Disease | Hysterectomy |  |
|  |  | Swelling of feet or legs |  |  |  | Thyroid Disorder | Sleep Apnea |  |
|  |  | Numbness/Tingling |  |  |  | Gastric Ulcers | Const ipation |  |
|  |  | Change in Menstrual Pattern |  |  |  | Unexplained Weight Loss |  |  |  |
|  |  | Extremely Painful Menses |  |  |  | Unexplained Weight Gain |  |  |
|  |  | Heavy Menstrual Flow |  |  |  | Urinary Tract Infection |  |  |
|  |  | Allergies |  |  |  | Asthma |  |  |
|  |  | Chicken Pox |  |  |  | Bronchitis |  |  |
|  |  |  | Chronic Lung Disease |  |  |
|  |  | Hepatitis A, B, or C |
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| **Surgical History** |  |
| **Surgery** | **Hospital** | **Surgeon** | **Year** |  |
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| **Current Diagnoses** |  |
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| **History and Physical Examination** |  |
|  |  |  |  |
| **Date Completed (Must be within the last year)** | **Physician Completing H&P** | **Results** |  |
|  |  |
| **Immunization History** |  |
| **Immunization** | **Date** |  |
| *Tetanus and Diphtheria (Td) Booster* |  |  |
| Measles Mumps, Rubella (MMR) Vaccination |  |  |
| Varicella Vaccination |  |  |
| Influenza Vaccination |  |  |
| Pneumococcal Polysaccharide Vaccination |  |  |
| Hepatitis A Vaccination |  |  |
| *Hepatitis B Vaccination* |  |  |
| *Hepatitis B Screening* | **Results:** |  |  |
| Meningococcal Vaccination |  |  |
| *TB Testing* | **Results:** |  |  |
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| --- |
| **Current Medications** |
|  |
| **Medication Order** | **Rationale/Diagnosis** | **Special Precautions** |

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|  |  |
| **Additional Physician’s Orders** |  |
|  |  |
|  |  |
| **Allergies** |  |
| **Allergen** | **Response** | **Special Precautions** |  |
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|  |  |
| **Labs** |  |
| **Lab Type** | **Date** | **Results** |  |
| CBC |  | See Attached |  |
| Chem Profile |  | See Attached |  |
| UA |  | See Attached |  |
| Free T4 |  | See attached |  |
| TSH |  | See Attached |  |
| PSA (if applicable) |  | See Attached |  |
|  |  |  |  |
|  |  |  |  |
|  |  |
| **Vital Signs/Weight: How often taken-** |  |
|  |  |  |  |  |  |  |
| **Pulse** | **Respirations** | **B/P** | **Temp** | **Weight** | **Height** |  |
|  |  |
| **Additional Medical Information/Comments****Describe special precautions, type/frequency of seizures, additional individual supports needed, etc.** |  |
|  |  |

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|  | **SPECIALISTS:** |  |
|  | Dental- Neurologist-Psychologist- (AIMS) Podiatry- Cardiologist- (EKG-) Colonoscopy/ PSA Pap/ Mammogram |  |
|  | ***Psychiatric Care/Behavioral Support*** |  |
|  |  |  |
|  |  |  |  |  |
|  | **Consulting Psychiatrist** | **City** | **Phone** |  |
|  | **Does the client exhibit any of the behaviors listed below?** | **Current Supports/Interventions** |  |
|  | Self-Abusive Behavior Physically Aggressive BehaviorSexually Aggressive/Inappropriate Behavior PedophiliaPicaAny behavior potentially harmful to self or others Elopement Risk | BSP/BMP *(See attached copy)* BRT Currently Consulting CounselingNeeds regular psychiatric follow-up Mandt/CPI RequiredPRN PsychotropicsBSP approved by HR and BSC |  |
|  |  |  |  |  | Provider staff trained on BSP |
|  |  |  |
|  | **Psychiatric Hospitalizations** |  |
|  | **Reason/Diagnosis** | **Facility** | **City** | **Year** |  |
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|  | ***Cognitive/Functional Status*** |  |
|  |  |  |
|  | **Intellectual Functioning Tests** |  |
|  | **Test** | **Score** | **Date** |  |
|  |  |  |  |  |
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|  | **Mental Status** |  |
|  | **General Observation -** Awake, Alert, Lethargic, Unresponsive, Interactive |  |
|  | **Mood -** Social, Passive, Depressed |  |
|  | **Orientation -** Person, Place, Time |  |
|  | **Communication -** Able to make needs known, NOT able to make needs known |  |
|  | **Short Term Memory -** Intact, Deficit Noted |  |
|  | **Long Term Memory -** Intact, Deficit Noted |  |
|  | **Following Instructions** - Follows Simple Commands, Follows Complex Commands (>2 steps) |  |
|  | **Comments:** Other target behaviors: (found in current BSP) Behavioral Concerns: Positive Characteristics: Likes:Dislikes:Must not have: |  |
|  |  |  |

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|  |  |
| **Communication** |  |
| **Interaction -** Readily conversant, Seldom initiates communication, Non-communicative |  |
|  |  |
| **Mode** - Verbal, Gestures/Nonverbal, Assisted Communication, Non-communicative |  |
|  |  |  |  |  |  |
|  | **Quality Expressive -** |  |  | Clear and easily understood, Difficult to understand, |  |
|  |  |  |  | Unintelligible |  |
|  |  |  |  |  |  |
|  | **Quality Receptive -** |  |  | No Deficits noted, Appears to have difficulty understanding, |  |
|  |  |  |  | Unable to comprehend at a functional level |  |
|  |  |
| **Hearing -** Facilitates conversation at normal levels, Deficit Noted, Deaf |  |
|  |  |  |  |  |  |
|  | **Current Supports -** |  |  | Communication Board, Picture Book, Communication Grid |  |
|  |  |  |  | Speak loudly, Speak slowly, Hearing Aid |  |
| **Comments:** |  |
|  |  |  |  |  |  |

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| **Vision** |  |
| Facilitates ADL’s, Deficits impairing ability to carry out ADL’s**Current Level of Vision -** |  |
|  |  | Blind |  |
|  | **Current Supports -** | Glasses, Contact Lenses, Escort |  |
| *(See Attached)* |  |
|  | **Date of Last Eye Exam** | **Results** |  |
| **Comments:** |  |
| **Mobility** |  |
|  | **Fall Risk** Yes, | No *(See Attached Fall Risk Assessment)* |  |
| **Mobility -** Ambulatory, Wheelchair, Other, Totally dependent upon staff for mobility |  |
| **Transfers -** Independent, Mechanical Assist, Staff Assist, Totally Dependent |  |
|  | **Bed Mobility/Repositi** | Independent, Mechanical Assist, Staff Assist**oning -** |  |
|  |  | Totally Dependent |  |
| **Comments:** |  |

**Choking Risk -** Yes, No

# Dietary/Meals

**Teeth -** Natural, Natural – Poor Repair/Teeth Missing, Dentures, Edentulous

## Is there a history of polydipsia/excessive fluid intake - Yes, No

**Current Physician Ordered Diet:**

Independent, Set-up Assistance Required, Requires Prompts, Requires Encouragement, Client must be fed by staff, Tube Feeding,

## Eating

**Drinking**

**Meal Preparation**

Requires special utensils, Requires special positioning/unique instructions Describe protocol, concerns and precautions

Independent, Requires prompting/reminders, Requires assistance, Requires special cup or glass, Requires special positioning/unique instructions, Tube feeding

Describe protocol, concerns and precautions

Independently and safely prepares basic meals requiring cooking Independently and safely prepares basic meals not requiring cooking Requires assistance with meal planning/making healthy choices Requires assistance when cooking

Requires assistance to prepare simple meals

Totally Dependent on staff for meal preparation

**Food Likes**

**Food Dislikes**

## Comments:

**Bladder**

**Bowel**

**Toileting**

Continent, Occasional Incontinence, Incontinent, Wears Depends, Catheter, Urostomy, Describe protocols, concerns, precautions Continent, Occasional Incontinence, Incontinent, Wears Depends Ileostomy, Colostomy, Describe protocols, concerns, precautions

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Perineal Care** | Independent, Requires prompts/reminders, Requires Assistance |  |
|  | **Date of last BM** |  | **Normal Bowel Routine** |  |  |
|  | **Comments:** |  |
|  |  |  |
|  |
|  | **Bathing/Hygiene/Grooming** |  |
|  | **Teeth** | Independent, Requires prompts/reminders, Requires setup assistance, Requires physical assistance, Totally dependent upon staffDate of last dental exam: |  |
|  | **Hair** | Independent, Requires prompts/reminders, Requires setup assistance,Requires physical assistance, Totally dependent upon staff |  |
|  | **Nails** | Independent, Requires prompts/reminders, Requires setup assistance,Requires physical assistance, Totally dependent upon staff, Diabetic |  |
|  | **Bath** | Independent, Requires prompts/reminders, Requires setup assistance,Requires physical assistance, Unable to regulate water temperature safely |  |
|  | **Dressing** | Independent, Requires prompts/reminders, Requires setup assistance,Requires physical assistance, Totally dependent upon staff |  |
|  | **Menses** | **Date: Characteristics:** |  |
|  | **Comments:** |  |
|  |  |  |
|  | **Household Chores** |  |
|  | **Cleaning** | Independent, Requires prompts/reminders, |  |
| Requires setup assistance, Requires physical assistance, |  |
| Totally dependent upon staff |  |
|  | **Washing Clothes** | Independent, Requires prompts/reminders, |  |
| Requires setup assistance, Requires physical assistance, |  |
| Totally dependent upon staff |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Household Chemicals** | Safe and appropriate use independently |  |
| Requires supervision during use |  |
| Must be locked away to ensure client safety |  |
|  | **Comments:** |  |
|  |
|  | **Adaptive Equipment** |  |
|  | **Type** | **Comments (When used, purpose, etc.)** |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  | ***Safety*** |  |
|  | **Water Temperature: See Cognitive/Functional Status** |  |
|  | **Current Level of Oversight – Home** (See Altered Levels of Supervision Tool) |  |
|  | **Staffing** | **24/7, Awake overnight, Asleep overnight,****< 24 hour supports – List hours:** |  |
|  | **Staffing Ratio:** | **1:1, 1:2, 1:3, 1:4, 1:5, 1:6, < 1:6** |  |
|  | **Intensity of Supervision:** | **Constant 1:1 Supervision, Line of Sight Supervision Knowledge of whereabouts at all times, Periodic Checks, Casual Observation** |  |
|  | Comments: |  |
|  | **Current Level of Oversight – Community** (See Altered Levels of Supervision Tool) |  |
|  | **Staffing Ratio:** | **1:1, 1:2, 1:3, 1:4, 1:5, 1:6, < 1:6** |  |
|  | **Intensity of Supervision:** | **Constant 1:1 Supervision, Line of Sight Supervision Knowledge of whereabouts at all times, Periodic Checks, Casual Observation** |  |
|  | **During van/car rides level of supervision: Comments:** |  |

|  |  |
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| **Emergency Situations/Community Safety** |  |
|  |  |  |  |  |
|  | **Able to utilize the phone to activate EMS appropriately?** | **Yes** | **No** |  |
|  | **Has knowledge of generally appropriate steps to take in response to a tornado?** | **Yes** | **No** |  |
|  | **Has knowledge of generally appropriate steps to take in response to a fire?** | **Yes** | **No** |  |
|  |  |  |  |  |
|  | **Interacts appropriately with strangers?** | **Yes** | **No** |  |
|  |  |  |  |  |
|  | **Takes necessary precautions when answering the door?** | **Yes** | **No** |  |
|  |  |  |  |  |
|  | **Able to interact safely in the community as a pedestrian?** | **Yes** | **No** |  |
|  |  |  |  |  |
|  | **Displays appropriate behavior when riding in vehicle?** | **Yes** | **No** |  |
| **Comments:** |  |

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| --- | --- |
|  |  |
| ***Vocational*** |  |
|  |  | **Current Employer Name** |  | **Supervisor Name** |  |
|  |  |  |  |  |  |
|  |  | **Employer Phone** | **Routine Work Schedule** |  |  |
|  |  |
| **Type of work performed** |  |
|  |  |
| **Work History (Last 5 jobs)** |  |
|  |  | **Employer** | **Type of Work** | **Reason for Leaving** |  |
|  |  |
|  |  |
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| **Vocational Goals** |  |
| **Full Time, Part-Time** |  |
|  |  |
| **Competitive Employment, Work Crew, Sheltered Workshop, Day Program** |  |
| **Type or work preferred:** |  |
| **List any non-preferred work types:** |  |
| **List any specific job skills:** |  |
| **List any job skills that need to be developed:** |  |
|  |  |
| **Preferred work environment: indoors, outdoors, work alone, work with a group** |  |
| **Work Restrictions/Other considerations: Transportation Needs:****List supports needed on the job:** |  |
|  |  |
| **Lifting Limits, Unable to stand for long periods of time, Requires special seating,****Requires grab bars in bathroom at work, Temperature limitations, Other:** |  |
| **Comments:** |  |
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| ***Hobbies/Activities*** |  |
| **Clubs** |  |
|  | **Name** | **Type** | **Contact Person** | **Phone** |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Leisure Activities** |  |
| **List leisure activities the client enjoys:** |  |
| **List any supports unique to hobbies/activities that must be provided:** |  |
| **Comments:** |  |
| ***Relationships*** |  |
| **Significant Other** |  |
|  |  |  |  |  |
|  | **Last Name** | **First Name** | **Relationship Type** |  |
|  |  |  |  |  |  |
|  | **Phone** | **Street** | **City** | **State** |  |
| **Frequency of contact:** |  |
| **Level of Intimacy:** |  |
| **Over-site requirements:** (i.e. Are they allowed time together alone) |  |
| **List any relationship skills that need to be developed:** |  |
|  |  |  |  |

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| --- | --- | --- |
|  | **Family/Friends** |  |
|  | **Name** | **Relationship** | **Contact Info** | **Restrictions by Guardian?** |  |
|  |  |  |  | **Yes** | **No** |  |
|  |  |  |  | **Yes** | **No** |  |
|  |  |  |  | **Yes** | **No** |  |
|  |  |  |  | **Yes** | **No** |  |
|  |  |  |  | **Yes** | **No** |  |
|  | How are family visits facilitated?Transportation needed?Issues?**Comments:** |  |
|  |  |  |

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| --- | --- | --- |
|  | ***Spiritual/Cultural*** |  |
|  | **Place of worship:** |  |
|  | **Times of worship:** |  |
|  | **Restrictions or Special Practices:** (i.e. does not celebrate holidays, dietary restrictions, etc.) |  |
|  | **Holidays/Traditions:** |  |

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| --- | --- |
| ***Home environment*** |  |
| **Preferences:** |  |
|  |  |
| **House, Apartment, Town, Country, Suburban, Fast Pace, Slow Paced, Retirement, Describe roommate preferences** |  |
|  |  |
| **Should high traffic areas be avoided?** |  |
| **Smoker, Non-Smoker** |  |
| **Are stairs OK?** |  |
| **List accommodations needed** (i.e grab bars, hoyer lift, etc.)**:** |  |
|  |  |
| ***Financial*** |  |
| **Payee** |  |
|  |  |  |  |  |  |  |  |  |
|  |  | **Name** |  |  |  | **Phone** |  |  |
|  |  |
| **Foodstamps** |  |
|  |  |  |  |  |  |  |  |  |
|  |  | **Amount** |  |  |  | **Next Date to Re-apply** | **Responsible Party** |  |
|  |  |
| **Monthly Income** |  |
|  |  | **Amount** |  |  |  | **Source** |  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Insurance/Medical Benefits** |  |
|  |  |
| **Medicaid, Medicaid Spenddown (Amount: ), Medicare Part A,****Medicare Part B** |  |
|  |  |
| **Other Insurance (Private, HMO, PPO, etc.)** |  |
|  |  | **Company Name** |  |  |  | **Policy Number** | **Contact Info** |  |
|  |  |
|  |  |
| **Personal Spending:** |  |
| **Monthly DMH Allowance:** |  |

|  |  |
| --- | --- |
| **Other Personal Spending Sources and amount:** |  |
| **Independently maintains personal spending, Requires assistance with budgeting, Requires assistance with maintaining security of personal spending money Limitations on amount of money the client can carry (Amount: )** |  |
| **Comments:** |  |
| ***Moving Plan*** |  |
| **Items to be moved/current inventory** |  |
|  |  | **Item** | **Person Responsible for Moving** |  |
|  | **Clothing/Needs:** |  |  |
|  | **Personal Items/Housewares:** |  |  |
|  | **Furniture** |  |  |
|  |  |
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| **Comments:** |  |

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| --- | --- | --- | --- |
| **Initial Transition Plan – Action Plan** | **Date:** |  |  |
|  |  |  |  |
| **Need Identified** | **Action to be Taken(Include timelines)** | **Responsible Party** | **SC Verified Complete Initial/Date** |
| Identify Primary Care Physician in or near the location of the proposed placement who will assume care of the individual as soon as possible after the date of transition and be available to provide medical advice and/or orders as may be necessary on the date of transition.Set an initial appointment with the primary care physician as soon as possible within 30 days of transition. At the initial appointment, the following will be discussed with the physician as applicable:1. Review of all meds
2. Review of all labs
3. Review of the most current physical
4. AIMS
5. Diet
6. EKG results and recommendation for future testing.
 |  |  |  |
| Identify dentist in or near the location of proposed placement who will assume care of the individual as soon as possible after transition. |  |  |  |
| Identify payment source for dental care. |  |  |  |
| Identify Eye Care Professional in or near the location of the proposed placement who will assume care of the individual as soon as possible after transition. |  |  |  |
| Identify a psychiatrist in or near the location of proposed placement who will assume care of the individual as soon as possible after transition. |  |  |  |
| Identify Pharmacy in or near the location of |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| proposed placement who will assume care of the individual as soon as possible after transition. |  |  |  |
| All prescribed medications available for administration in the home on the date of transition. |  |  |  |
| Physician’s orders shall accompany the individual from the habilitation center on the date of the move and shall be reviewed by the new Primary Care Physician at the initial visit. |  |  |  |
| Staff who are familiar with the listed diagnoses, symptoms commonly associated with the diagnoses, when and to whom symptoms should be reported, and how the listed diagnoses affect the individual’s daily life. Any necessary staff training to be provided to all staff prior to working with the individual. |  |  |  |
| Staff who are familiar with medications listed in the current medication regimen, the intended therapeutic effect of each medication, side effects commonly associated with each medication, and when and to whom any failure for the medication to provide the intended therapeutic effect or the presence of side effects should be reported. Any necessary staff training to be provided to all staff prior to working with the individual. |  |  |  |
| Provide a copy of the current physician’s orders and/or list of medications currently administered in the current living environment to the new provider prior to the date of transition. |  |  |  |
| Provide a copy of a CBC (Blood Test) completed within the last year to the chosen provider prior to the date of transition. |  |  |  |
| Provide a copy of a Chem Profile completed within the last year to the chosen provider prior to the date of transition. |  |  |  |

|  |  |  |  |
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| Provide a copy of a UA completed within the last year to the chosen provider prior to the date of transition. |  |  |  |
| Provide a copy of a History and Physical examination completed within the last year to the chosen provider prior to the date of transition.The history and physical should be typed or legibly handwritten and include a review of all body systems including genital and rectal exams, as well as testicular and prostate exams for men, and breast exam and PAP smear for women. |  |  |  |
| Provide a copy of a dental exam completed within the last year to the chosen provider prior to the date of transition. |  |  |  |
| Provide a copy of an eye exam completed within the last year to the chosen provider prior to the date of transition. |  |  |  |
| Provide a copy of TB testing completed within the last year to the chosen provider prior to the date of transition. |  |  |  |
| Provide a copy of documentation showing administration of a tetanus booster administered within the last 10 years to the chosen provider prior to the date of transition. |  |  |  |
| Provide a copy of documentation showing administration of the MMR vaccine to the chosen provider prior to the date of transition. |  |  |  |
| Provide a copy of documentation showing administration of the Hepatitis B Immunization Series to the chosen provider prior to the date of transition. |  |  |  |
| Community RN of chosen provider agency to conduct full nursing assessment on the date of transition. |  |  |  |
| Annual Lab Work: To include CBC, CMP, UA, |  |  |  |

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| and Stool Culture |  |  |  |
| Head to toe skin assessment to be conducted at the time of transition documenting any skin breakdown and bruises or other injuries on the EMT form. |  |  |  |
| Document heart rate, respiratory rate, blood pressure, temperature, weight, and a general assessment of the individual’s level of consciousness at the time of transition. |  |  |  |
| Provide current MAR to provider on date of transition which includes documentation of medications administered on the date of transition. |  |  |  |
| Chosen provider to obtain Authorization for Release of Protected Health Information from currently consulting professionals and organizations involved with the individual’s care as necessary to obtain pertinent health information prior to the date of transition. |  |  |  |
| Regional Center RN to conduct Nursing Review within 30 days following the date of transition. |  |  |  |
| Diet/Meals:1. Must follow the diet as prescribed by physician.
2. Plan for supplements if needed.
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| ADL’s: 1) Requires verbal prompts/reminders and assistance to complete. |  |  |  |
| Safety/Level of Supervision: |  |  |  |
| Work/Day Habilitation: |  |  |  |
| Activities:Individual must continue to be able to participate in enjoyed activities and events and have opportunities to participate in new activities and events that he/she might grow to enjoy. |  |  |  |

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| All staff will be trained in Positive Behavior Support prior to the transition. |  |  |  |
| A Behavior Support Plan will be developed and approved for implementation prior to the date of transition, when needed by the individual served.All staff will be trained in the implementation of BSP prior to the date of transition. |  |  |  |
| Financial/Money:1. Will require assistance to budget his money.
2. Family Services will be notified of the move from habilitation center to the community to avoid interruption in Medicaid.
3. Social Security office will be notified of the move from habilitation center to the community.
4. Application will be made to Social Security for maximum benefits.
5. Application for change in payee will be completed.
6. Foodstamps application with FSD will be completed.
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| Household Furnishings:A list of household furnishings needed will be developed by the agency and provided to the Transition Coordinator/TCM Entity for submission to the UR Committee per Division Directive 5.050 |  |  |  |
| Funding of Services:A budget will be turned into the TCM Entity/Transition Coordinator/TCM Entity for submission to receiving RO’s UR Committee. |  |  |  |
| Referrals will be made for all community supports |  |  |  |

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| needed (residential, work, transportation, adaptive equipment, counseling, therapies, etc.) |  |  |  |
| Identified service gaps are reported to Regional Office Provider Relations Team Member for development or expansion of needed service in the community. |  |  |  |
| IPC or other funding authorization and all waiver paperwork has been completed for all services needing funding. |  |  |  |
| Transition Coordinator/TCM entity determines if the individual qualifies for the Money Follows the Person grant. If so, the MFP paperwork is completed and submitted to the MFP Project Director. |  |  |  |
| Provider Follow-up:1. Visits are scheduled for staff to shadow individual at habilitation center.
2. Visits are scheduled for individual to visit new home.
3. Discuss roommate issues, preferences, etc.
4. Will individual share bedroom with another individual?
5. If this is a new ISL, has home been inspected/approved by receiving RO?
6. Follow up with any city ordinances regarding development of new ISL home
7. Does provider need to hire/train staff?
8. Are home modifications needed? – submit proposals and bids to UR committee for approval
9. Describe a typical day for someone in this home.
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| Post-Move Follow-Up:Schedule 30-60-90 Day meetings: |  |  |  |
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