INDIVIDUAL'S NAME	ADSA ID NUMBER	MOVE DATE

INDIVIDUAL'S STATED TRANSITION GOAL

INDIVIDUAL'S STATED SUPPORTS NEEDED TO ACHIEVE GOAL

INDIVIDUAL'S PROGRAM

☐ RCL ☐ OHS ☐ CIIS ☐ IMH ☐ TCU ☐ Non-Specialized

Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENT DISABILITIES ADMIISTRATION (DDA)

Transitional Care Planning and Tracking
Part C. Post Move and Stabilization

Purpose: This is a required document for DDA staff coordinating a move from one setting to another. Case Managers will use this document with each individual to support post move follow-up tasks, monitor risks for instability and ensure all supports and services are in place and meeting the needs of the individual.

C. Post Move and Stabilization

The case manager checks in with the individual to ensure they are adjusting, ensure that staff are trained and implementing planned strategies to support the individual, and that all plans are in place and being implemented. The Post Move and Stabilization stage is 365 days after the individual moves into their permanent home. Complete Part C of this form for the check ins and follow up for two - three day check in; two week virtual meeting; and 30 day home visit.

HOME ADDRESS: STREET	CITY	STATE	ZIP CODE

Two – three business days post move – individual is getting settled.	**Check in call date:**
ACTIVITY	**NOTES**
Individual is getting to know staff	
Provider is comfortable with supports in place	
Issues with behaviors, nutrition, medications, etc.	
Initial draft FA / PBSP in place and staff trained, if applicable	
Nurse delegation is in place and medications are being used (if no concern and follow up must be documented below)	
Concerns (is the client missing any key / needed supports that need to be prioritized, behaviors or other factors increasing risk of losing housing and/or provider)	
Two weeks post move – staff are able to address client's needs.	**Virtual meeting date:**
Individual is comfortable with staff	
Provider understands individual's support needs and comfort with interventions	
Issues with behaviors, nutrition, medications, etc.	
Individual is satisfied with sleep and daily routine	

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Individual is planning community activities of interest		
Individual shares general feedback about their experience so far		
Concerns (is the client missing any key / needed supports that need to be prioritized, behaviors or other factors increasing risk of losing housing and/or provider)	PLANNED FOLLOW UP:	FOLLOW UP DATE

30 days post move – plans are all in place.	**Home visit date:**
Provider has finalized IISP, NCP, or other relevant care plans	
Home is decorated and personalized per the individual's preference	
All staff have completed needed or required training to meet individual's needs	
Individual is participating in community activities of interest	
Concerns (is the client missing any key / needed supports that need to be prioritized, behaviors or other factors increasing risk of losing housing and/or provider)	PLANNED FOLLOW UP: / FOLLOW UP DATE

Upon completion of the 30-day visit this form must be uploaded into RMT under Plans ➔ Transitional Care Management Quarterly plan reviews must be completed in CARE.

CIIBS, OHS, ECMP	Complete quarterly visits every 90 days and document in CARE specialized program node for CIBS, Out of Home Services, and Enhanced Case Management.
Transition, RCL, IMH, CP	Complete quarterly visits every 90 days and document in CARE plan review screen for Transition, RCL, Intensive Mental Health, and Community Protection caseloads.