| INDIVIDUAL’S NAME | ADSA ID NUMBER | PROPOSED MOVE DATE |
| --- | --- | --- |
| INDIVIDUAL’S STATED TRANSITION GOAL |
| INDIVIDUAL’S STATED SUPPORTS NEEDED TO ACHIEVE GOAL |
| INDIVIDUAL’S PROGRAM[ ]  RCL [ ]  OHS [ ]  CP [ ]  CIIS [ ]  IMH [ ]  ECMP [ ]  TCU [ ]  Non-Specialized |
|  |  DEVELOPMENT DISABILITIES ADMIISTRATION (DDA) **Transitional Care Planning and Tracking** **Part B. Active Coordination of Transition (ACT)** |
| Purpose: This document is intended to be used as a facilitation guide and tracker for DDA staff coordinating a move from one setting to another. Case Managers who are facilitating care coordination meetings will use this document to track progress and highlight individual needs and readiness to transition to their identified setting. A copy will be provided to the individual and their representative to update them on transition progress as well as to transition team members as appropriate. |
| **B. Active Coordination of Transition (ACT): Team meets regularly to support transition** |
| **Transition Team**The transitional care coordination team meets regularly to develop and implement the care plan, identify medical, dental, referral and assessment needs, set up housing, identify and implement environmental modifications and equipment needs, confirm financial eligibility, and facilitate introductions to providers, roommates, and community activities. |
| HOME ADDRESS: STREET CITY STATE ZIP CODE |
| **TITLE / ORGANIZATION** | **NAME** | **ROLE** | **CONTACT INFORMATION** |
| Individual |  | Engage with the team on community living goals and preferences |  |
| DDA Case Manager |  | Facilitate transitional care coordination meetings; coordinate assignments and deadlines; model person centered practices |  |
| Current / Sending Provider |  | Provide expertise regarding individual’s care needs |  |
| Medical Provider |  | Discuss medical supports needed, including post move medications and referrals to appropriate PCP or specialists if needed |  |
| Behavioral Health Provider |  | Discuss behavioral supports needed, including post move psych medications and FA/PBSP coordination |  |
| DDA HQ Transition Clinical Staff |  | If identified high medical or behavioral acuity, or if otherwise needed for consultation |  |
| Receiving Provider |  | The agency or responsible provider of services in the setting where the individual will move |  |
| Guardian or Representative |  | Support the individual with decision making regarding the implementation of their goals and their needed supports and services |  |
| School Representative (Youth under 21) |  | Ensure that the individual’s needs are captured in their IDEA and they have access to all needed IDEA Part B services in their new home |  |
| WISE Representative, if applicable |  | Ensure that individual’s wrap around supports are reflected in their child and family team care plan |  |
| Managed Care Representative |  | Primary contact for all Apple Health funded services |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Instructions:**  Invite all persons who are identified to attend the initial meeting. Prior to each subsequent meeting, review expected updates and ensure that the persons responsible for those updates will be on the agenda and attending the meeting. When a person is expected to follow up on a task, put their name in the column “person responsible” and enter a date when they will be reporting back to the team. Add a note on what task they will be completing and the status updates for those tasks. Change the expected update date as needed. Check “done” when the task is completed, and the date. |
| **HOUSING** | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Environmental modifications needed / set up |  |  |  | [ ]  |  |
| Rental application and lease completed / in place |  |  |  | [ ]  |  |
| Furnishings and décor |  |  |  | [ ]  |  |
| Resource management |  |  |  | [ ]  |  |
| Meet staff, roommates, and visit home |  |  |  | [ ]  |  |
| NOTES |
| **BEHAVORIAL SUPPORTS** | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Psychiatric needs, including prescriber, if needed |  |  |  | [ ]  |  |
| Community behavioral health provider identified and follow up |  |  |  | [ ]  |  |
| FA / PBSP |  |  |  | [ ]  |  |
| Cross Systems Crisis Plan (CSCP) or safety plan, if needed |  |  |  | [ ]  |  |
| Behavior related IR follow up needed |  |  |  | [ ]  |  |
| WISe screening needed (youth) |  |  |  | [ ]  |  |
| New / emerging behavioral support needs |  |  |  | [ ]  |  |
| NOTES |
| **MEDICAL AND DENTAL**  | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| MCO care coordination needs |  |  |  | [ ]  |  |
| Primary care confirmed |  |  |  | [ ]  |  |
| Specialists needed are in place |  |  |  | [ ]  |  |
| Dentist |  |  |  | [ ]  |  |
| Therapy needs:* PT / OT / ST
* Dietary
 |  |  |  | [ ]  |  |
| New / emerging needs |  |  |  | [ ]  |  |
| NOTES |
| **FINANCIAL AND LEGAL** | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Verify SSI, SSDI, and other unearned income in place |  |  |  | [ ]  |  |
| Establish payee if needed, and review financial supports for plan |  |  |  | [ ]  |  |
| Apply for food programs, if eligible |  |  |  | [ ]  |  |
| Are they on the correct funding program (RCL / Waiver)? |  |  |  | [ ]  |  |
| Reconcile finances in current setting |  |  |  | [ ]  |  |
| Guardianship paperwork in place, if applicable |  |  |  | [ ]  |  |
| Bank account is setup in new location |  |  |  | [ ]  |  |
| NOTES |
| **SERVICES SET UP** | **PERSON RESPONSIBLE** | **EXPECTED UPDATES** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Confirm or initiate waiver or RCL enrollment |  |  |  | [ ]  |  |
| Nurse delegator identified* Medication assistance needs are identified
* Date of move nurse delegation scheduled
 |  |  |  | [ ]  |  |
| Adaptive / AT equipment in place for sensory, communication, and ADL needs |  |  |  | [ ]  |  |
| Employment / community inclusion |  |  |  | [ ]  |  |
| Transportation needs* Will individual need specialized transportation to access their community? Who will transport them to upcoming appointments?
 |  |  |  | [ ]  |  |
| School for clients under 21 |  |  |  | [ ]  |  |
| * School enrollment confirmed
* IEP transfer is completed or in process
 |  |  |  | [ ]  |  |
| DSHS 16-271, DDA New School District Notification, following Mutual Acceptance into OHS has been completed and sent to parent. |  |  |  | [ ]  |  |
| NOTES |
| **STAFF TRAINING** | **PERSON RESPONSIBLE** | **EXPECTED UPDATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Nurse delegation is in place for all staff |  |  |  | [ ]  |  |
| Staff are trained on all care plans and individual support needs |  |  |  | [ ]  |  |
| NOTES |
| **Prior to move in date** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Current provider / new provider consultation |  | [ ]  |  |
| All needed documents are in client provider file |  | [ ]  |  |
| All previous tasks have been reviewed and completed |  | [ ]  |  |
| All plans are in place | [ ]  PBSP [ ]  CSCP[ ]  IISP [ ]  Protocols | [ ]  Other |
| NOTES |
| **DAY OF MOVE** | **PERSON RESPONSIBLE** | **DUE DATE** | **NOTES AND STATUS UPDATES** | **DONE** | **DATE** |
| Transportation to new home |  |  |  | [ ]  |  |
| Items to be moved* Property list confirmed
 |  |  |  | [ ]  |  |
| Provider receives medications and MAR  |  |  |  | [ ]  |  |
| Finances are transferred |  |  |  | [ ]  |  |
| Arrangements for meals enroute |  |  |  | [ ]  |  |
| Confirm the move on theDSHS 15-345 LTC form |  |  |  | [ ]  |  |
| [ ]  Confirm the move on the DSHS LTC form |
| NOTES |