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|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **Residential Transition Exchange of Information** | | CLIENT NAME | | |
| 1. Use this form when one service provider is ending services and a new service provider is starting services. 2. Write in additional relevant items not displaced on the lists below as appropriate to the client. 3. Receive provider checks to confirm they have received each item. 4. Both the sending and receiving providers sign this form to verify which items have been delivered and received. | | | | | |
| **Plans and Protocols** | | | RECEIVED | NOT RECEIVED | NOT APPLICABLE |
| Individual Instruction and Support Plan (IISP) | | |  |  |  |
| Positive Behavior Support Plan (PBSP) | | |  |  |  |
| Functional assessment (FA) | | |  |  |  |
| Individual Financial Plan (IFP) | | |  |  |  |
| Psychotropic Medication Treatment Plan (PMTP) | | |  |  |  |
| Cross System Crisis Plan (CSCP) | | |  |  |  |
| Health Care Plan (HCP) | | |  |  |  |
| Seizure protocol | | |  |  |  |
| Bowel protocol | | |  |  |  |
| Swallowing protocol | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
| **Medical Information** | | | RECEIVED | NOT RECEIVED | NOT APPLICABLE |
| Medication orders (60 days worth) | | |  |  |  |
| Medication Administration Record (MAR) (including current month) | | |  |  |  |
| Received all medications listed on the MAR | | |  |  |  |
| Med count was completed | | |  |  |  |
| Medical devices | | |  |  |  |
| Medical Device consent | | |  |  |  |
| Medical Device orders | | |  |  |  |
| Current list of medical providers | | |  |  |  |
| List of upcoming medical appointments | | |  |  |  |
| Medical appointment results | | |  |  |  |
| Nurse Delegation consents | | |  |  |  |
| Nurse Delegation task sheets | | |  |  |  |
| Lab Results | | |  |  |  |
| Skin Integrity Checks | | |  |  |  |
| Immunization records | | |  |  |  |
| Consents for medication management | | |  |  |  |
| Medical History | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
| **Tracking Forms (13-months worth)** | | | RECEIVED | NOT RECEIVED | NOT APPLICABLE |
| Bath Water Temperature | | |  |  |  |
| Bowel Movement | | |  |  |  |
| Fire Drill | | |  |  |  |
| Fluid Tracking | | |  |  |  |
| Weight Log | | |  |  |  |
| Personal Care | | |  |  |  |
| Seizure Tracking | | |  |  |  |
| Actual food intake | | |  |  |  |
| Sleep Tracking | | |  |  |  |
| Activity Logs | | |  |  |  |
| Behavior Tracking | | |  |  |  |
| Repositioning / Freshening | | |  |  |  |
| Blood Glucose | | |  |  |  |
| Blood Pressure | | |  |  |  |
| Female Health Record | | |  |  |  |
| Refusal Tracking | | |  |  |  |
| Goal Tracking | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
| **Financial and Property** | | | RECEIVED | NOT RECEIVED | NOT APPLICABLE |
| Representative Payee status | | |  |  |  |
| EBT card and code: | | |  |  |  |
| Account: Type: Amount: **$** | | |  |  |  |
| Account: Type: Amount: **$** | | |  |  |  |
| Account: Type: Amount: **$** | | |  |  |  |
| Property Record (received all items listed) | | |  |  |  |
| Deposit reimbursement | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
| **Legal** | | | RECEIVED | NOT RECEIVED | NOT APPLICABLE |
| Social Security Card (send originals and keep a copy) | | |  |  |  |
| Guardianship paperwork | | |  |  |  |
| Birth Records (send originals and keep a copy) | | |  |  |  |
| Funeral Plan(send originals and keep a copy) | | |  |  |  |
| Release of information for clients | | |  |  |  |
| Advanced Directives / POLST / DNR (send originals and keep a copy) | | |  |  |  |
| Copy of lease | | |  |  |  |
| List of maintenance items submitted to landlord for repair | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
| **Miscellaneous** | | | RECEIVED | NOT RECEIVED | NOT APPLICABLE |
| Identification Cards(send originals and keep a copy) | | |  |  |  |
| Insurance Cards(send originals and keep a copy) | | |  |  |  |
| Handicap ID and Placard(send originals and keep a copy) | | |  |  |  |
| Housing Voucher | | |  |  |  |
| Exceptions to rule or policy | | |  |  |  |
| Employment records and work schedule | | |  |  |  |
| Incident Reports | | |  |  |  |
| Weapons Agreement | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
| **CP (if applicable)** | | | RECEIVED | NOT RECEIVED | NOT APPLICABLE |
| Current and past Treatment Plans | | |  |  |  |
| Department of Corrections / CCO contact (if applicable) | | |  |  |  |
| CP reductions in place | | |  |  |  |
| Chaperone approvals | | |  |  |  |
| Level and notification requirements (if applicable) | | |  |  |  |
| Current site approval if client is remaining in home | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
|  | | |  |  |  |
| **Provider Information** | | | | | |
| **Sending** agency confirms all noted items are provided. | | SIGNATURE DATE | | | |
| PRINTED NAME | | | |
| COMMENTS | | | | | |
| **Receiving** agency confirms all noted items are received. | | SIGNATURE DATE | | | |
| PRINTED NAME | | | |
| COMMENTS | | | | | |
| **Providers are responsible to seek own legal counsel regarding disclosure of information.** | | | | | |