

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				
<i>To be completed within 30 days</i>	<i>See Attached</i>	<i>See Attached</i>	<i>See Attached</i>	<i>To be Completed within 30 Days</i>
Annual Personal Plan	Choice of Provider / Waiver Choice	ICF-MR Level of Care	Health Inventory	Nursing Review

Services				
Service Requested / Identified Provider	UR Approved YES	NO	Requested Start Date	Authorized Date
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

Health and Medical

Current Consulting Professionals

Name	Type	City	Phone

Medical History

<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/> Bleeding/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Oxygen Use
<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	STD's	<input type="checkbox"/>	Wheezing
<input type="checkbox"/> Blood Sugar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	Other Respiratory Disorder
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	Ear, Nose, Throat Trouble
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Eye Disorder
<input type="checkbox"/> Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus Ulcer/Skin Breakdown	<input type="checkbox"/>	Headaches
<input type="checkbox"/> Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	Vision Loss
<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder problems	<input type="checkbox"/>	Seizures or Epilepsy
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Stroke
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Substance Abuse
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Hysterectomy
<input type="checkbox"/> Swelling of feet or legs	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Ulcers	<input type="checkbox"/>	Constipation
<input type="checkbox"/> Change in Menstrual Pattern	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Weight Loss	<input type="checkbox"/>	
<input type="checkbox"/> Extremely Painful Menses	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Weight Gain	<input type="checkbox"/>	
<input type="checkbox"/> Heavy Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	
<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	
<input type="checkbox"/> Hepatitis A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>	

Surgical History

Surgery	Hospital	Surgeon	Year

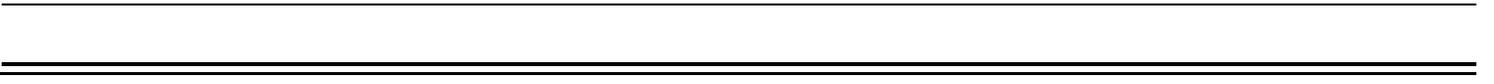
Current Diagnoses

History and Physical Examination

Date Completed (Must be within the last year)	Physician Completing H&P	Results

Immunization History

Immunization	Date
<i>Tetanus and Diphtheria (Td) Booster</i>	
Measles Mumps, Rubella (MMR) Vaccination	
Varicella Vaccination	
Influenza Vaccination	
Pneumococcal Polysaccharide Vaccination	
Hepatitis A Vaccination	
<i>Hepatitis B Vaccination</i>	
<i>Hepatitis B Screening</i>	Results: <input type="text"/>
Meningococcal Vaccination	
<i>TB Testing</i>	Results: <input type="text"/>



Additional Physician's Orders

Allergies

Allergen	Response	Special Precautions

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.

SPECIALISTS:

Dental-

Neurologist-

Psychologist- (AIMS)

Podiatry-

Cardiologist- (EKG-)

Colonoscopy/ PSA

Pap/ Mammogram

Psychiatric Care/Behavioral Support

Consulting Psychiatrist	City	Phone																		
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center;">Does the client exhibit any of the behaviors listed below?</th> <th style="width: 50%; text-align: center;">Current Supports/Interventions</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Self-Abusive Behavior</td> <td><input type="checkbox"/> BSP/BMP (<i>See attached copy</i>)</td> </tr> <tr> <td><input type="checkbox"/> Physically Aggressive Behavior</td> <td><input type="checkbox"/> BRT Currently Consulting</td> </tr> <tr> <td><input type="checkbox"/> Sexually Aggressive/Inappropriate Behavior</td> <td><input type="checkbox"/> Counseling</td> </tr> <tr> <td><input type="checkbox"/> Pedophilia</td> <td><input type="checkbox"/> Needs regular psychiatric follow-up</td> </tr> <tr> <td><input type="checkbox"/> Pica</td> <td><input type="checkbox"/> Mandt/CPI Required</td> </tr> <tr> <td><input type="checkbox"/> Any behavior potentially harmful to self or others</td> <td><input type="checkbox"/> PRN Psychotropics</td> </tr> <tr> <td><input type="checkbox"/> Elopement Risk</td> <td><input type="checkbox"/> BSP approved by HR and BSC</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Provider staff trained on BSP</td> </tr> </tbody> </table>			Does the client exhibit any of the behaviors listed below?	Current Supports/Interventions	<input type="checkbox"/> Self-Abusive Behavior	<input type="checkbox"/> BSP/BMP (<i>See attached copy</i>)	<input type="checkbox"/> Physically Aggressive Behavior	<input type="checkbox"/> BRT Currently Consulting	<input type="checkbox"/> Sexually Aggressive/Inappropriate Behavior	<input type="checkbox"/> Counseling	<input type="checkbox"/> Pedophilia	<input type="checkbox"/> Needs regular psychiatric follow-up	<input type="checkbox"/> Pica	<input type="checkbox"/> Mandt/CPI Required	<input type="checkbox"/> Any behavior potentially harmful to self or others	<input type="checkbox"/> PRN Psychotropics	<input type="checkbox"/> Elopement Risk	<input type="checkbox"/> BSP approved by HR and BSC	<input type="checkbox"/>	<input type="checkbox"/> Provider staff trained on BSP
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Psychiatric Hospitalizations

Reason/Diagnosis	Facility	City	Year

Cognitive/Functional Status

Intellectual Functioning Tests

Test	Score	Date

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:

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:

Vision

Current Level of Vision - Facilitates ADL's, Deficits impairing ability to carry out ADL's
 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/Repositioning - Independent, Mechanical Assist, Staff Assist
 Totally Dependent

Comments:

Dietary/Meals

Choking Risk - Yes, No

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

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

Current Physician Ordered Diet:

Eating	<input type="checkbox"/> Independent, <input type="checkbox"/> Set-up Assistance Required, <input type="checkbox"/> Requires Prompts, <input type="checkbox"/> Requires Encouragement, <input type="checkbox"/> Client must be fed by staff, <input type="checkbox"/> Tube Feeding, <input type="checkbox"/> Requires special utensils, <input type="checkbox"/> Requires special positioning/unique instructions <input type="checkbox"/> Describe protocol, concerns and precautions
Drinking	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompting/reminders, <input type="checkbox"/> Requires assistance, <input type="checkbox"/> Requires special cup or glass, <input type="checkbox"/> Requires special positioning/unique instructions, <input type="checkbox"/> Tube feeding <input type="checkbox"/> Describe protocol, concerns and precautions
Meal Preparation	<input type="checkbox"/> Independently and safely prepares basic meals requiring cooking <input type="checkbox"/> Independently and safely prepares basic meals not requiring cooking <input type="checkbox"/> Requires assistance with meal planning/making healthy choices <input type="checkbox"/> Requires assistance when cooking <input type="checkbox"/> Requires assistance to prepare simple meals <input type="checkbox"/> Totally Dependent on staff for meal preparation

Food Likes

Food Dislikes

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Comments:

Toileting

Bladder	<input type="checkbox"/> Continent, <input type="checkbox"/> Occasional Incontinence, <input type="checkbox"/> Incontinent, <input type="checkbox"/> Wears Depends, <input type="checkbox"/> Catheter, <input type="checkbox"/> Urostomy, <input type="checkbox"/> Describe protocols, concerns, precautions
Bowel	<input type="checkbox"/> Continent, <input type="checkbox"/> Occasional Incontinence, <input type="checkbox"/> Incontinent, <input type="checkbox"/> Wears Depends <input type="checkbox"/> Ileostomy, <input type="checkbox"/> Colostomy, <input type="checkbox"/> Describe protocols, concerns, precautions

Perineal Care	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompts/reminders, <input type="checkbox"/> Requires Assistance		
Date of last BM		Normal Bowel Routine	
Comments:			

Bathing/Hygiene/Grooming

Teeth	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompts/reminders, <input type="checkbox"/> Requires setup assistance, <input type="checkbox"/> Requires physical assistance, <input type="checkbox"/> Totally dependent upon staff Date of last dental exam:		
Hair	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompts/reminders, <input type="checkbox"/> Requires setup assistance, <input type="checkbox"/> Requires physical assistance, <input type="checkbox"/> Totally dependent upon staff		
Nails	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompts/reminders, <input type="checkbox"/> Requires setup assistance, <input type="checkbox"/> Requires physical assistance, <input type="checkbox"/> Totally dependent upon staff, <input type="checkbox"/> Diabetic		
Bath	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompts/reminders, <input type="checkbox"/> Requires setup assistance, <input type="checkbox"/> Requires physical assistance, <input type="checkbox"/> Unable to regulate water temperature safely		
Dressing	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompts/reminders, <input type="checkbox"/> Requires setup assistance, <input type="checkbox"/> Requires physical assistance, <input type="checkbox"/> Totally dependent upon staff		
Menses	Date:	Characteristics:	

Comments:

Household Chores

Cleaning	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompts/reminders,
	<input type="checkbox"/> Requires setup assistance, <input type="checkbox"/> Requires physical assistance,
	<input type="checkbox"/> Totally dependent upon staff
Washing Clothes	<input type="checkbox"/> Independent, <input type="checkbox"/> Requires prompts/reminders,
	<input type="checkbox"/> Requires setup assistance, <input type="checkbox"/> Requires physical assistance,
	<input type="checkbox"/> Totally dependent upon staff

Household Chemicals	<input type="checkbox"/> Safe and appropriate use independently
	<input type="checkbox"/> Requires supervision during use
	<input type="checkbox"/> Must be locked away to ensure client safety

Comments:

Adaptive Equipment	
Type	Comments (When used, purpose, etc.)

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:

Emergency Situations/Community Safety

Able to utilize the phone to activate EMS appropriately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has knowledge of generally appropriate steps to take in response to a tornado?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has knowledge of generally appropriate steps to take in response to a fire?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Interacts appropriately with strangers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Takes necessary precautions when answering the door?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Able to interact safely in the community as a pedestrian?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Displays appropriate behavior when riding in vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Comments:

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

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:

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:

Family/Friends

Name	Relationship	Contact Info	Restrictions by Guardian?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

How are family visits facilitated?

Transportation needed?

Issues?

Comments:

Spiritual/Cultural

Place of worship:

Times of worship:

Restrictions or Special Practices: (i.e. does not celebrate holidays, dietary restrictions, etc.)

Holidays/Traditions:

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, hooyer 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	

Comments:

Initial Transition Plan – Action Plan		Date:	
Need Identified	Action to be Taken(Include timelines)	Responsible Party	SC Verified Complete Initial/Date
<p>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.</p> <p>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:</p> <ol style="list-style-type: none"> 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.			

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.			
<u>Annual Lab Work:</u> To include CBC, CMP, UA,			

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.			
<u>Diet/Meals:</u> 1) Must follow the diet as prescribed by physician. 2) Plan for supplements if needed.			
<u>ADL's:</u> 1) Requires verbal prompts/reminders and assistance to complete.			
<u>Safety/Level of Supervision:</u>			
<u>Work/Day Habilitation:</u>			
<u>Activities:</u> 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.			

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.			
<u>Financial/Money:</u> 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.			
<u>Household Furnishings:</u> 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			
<u>Funding of Services:</u> 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			

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.			
<u>Provider Follow-up:</u> <ol style="list-style-type: none"> 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. 			

Post-Move Follow-Up: Schedule 30-60-90 Day meetings:			