**Residential Transition Checklist**

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| **Individuals Name:**       | **Date of Birth:**       | **DMH ID:**       |
| **Chosen Provider County & Address:**       | **Date Provider Choice Form Signed**: (requirement)  |
| **Transitioning from (Provider):** | **Transitioning to (Provider):** |
| **Sending TCM & Support Coordinator:**  | **Receiving TCM & Support Coordinator:**  |
| **Sending Regional Office:**  | **Receiving Regional Office:**  |
| **New Address:** | **New Phone Number:**  |
| **Tentative Move Date:** | **Actual Move Date:**  |

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| Initial Transition Meeting Date**:**  | Post Move Transition Meeting Date:       |
| Invited Required Team Members: * Individual (if able to attend)
* Current and New Provider
* Sending SC or Representative
* Receiving SC or Representative
* Legal Guardian or PA
* Behavior Analyst or Medical Provider
* Regional Office Nurse (optional)
 | Document Who Attended Meeting:  |

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| **Section A**: Choosing a Provider  |

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| 1. Implementation date of current ISP.
 | Date: | Completed By: | Description**:** |
| 1. How did the team and individual/Guardian assess compatibility with potential housemates?
 | Date:  | Completed By: | Description:  |
| 1. Did the team discuss with potential housemate guardians or individuals if this new housemate would be a good fit for them prior to the move?
 | Date: | Completed By: | Description:  |
| 1. Was the team able to assess the level of risk for each potential housemates would present to one another?
 | Date: | Completed By: | Description:  |
| 1. Was the Individual able to visit the new home and meet potential housemates prior to choosing provider?
 | Date: | Completed By: | Description:  |
| 1. Do any of the potential housemates have limitations to their rights? If so, this must be discussed.
 | Date: | Completed By: | Description:  |
| 1. How does the receiving provider plan to support the needs of the individual?
 | Date: | Completed By: | Description:  |
| 1. Identify all waivered and non-waivered support needs here. Are these supports available in the area the individual is moving to?
 | Date: | Completed By: | Description:  |
| 1. What is the team’s plan for the following?
	1. Are staffing level needs identified?
	2. If necessary, what is the plan for reduction and timeline as identified by receiving provider?
 | Date: | Completed By: | List Services:  |
| 1. Has Utilization Review (UR) been approved?
	1. If approved, please send copy of approval to the receiving SC.
	2. If not approved, please list date of expecting to have approval.
 | Date: | Completed By: | Description:  |
| 1. Does a site review need to be completed on this home?
 | Date: | Completed By: | Description:  |
| 1. Were there any repairs/changes necessary per site review before move in? If yes, status of completion:
 | Date: | Completed By: | Description:  |
| 1. Are any home modifications needed? What is the plan for completion and will this delay or prevent the move?
 | Date: | Completed By: | Description: |
| 1. Does the individual have sufficient benefits to cover room and board costs including personal spending of at least thirty dollars? If not what is the plan?
 | Date: | Completed By: | Description:  |
| 1. Does the individual have any pending legal issues?
 | Date: | Completed By: | Description:  |
| 1. Does the individual have overdue/unpaid bills? If so, who will be responsible?
 | Date: | Completed By: | Description:  |
| 1. Who is the current payee?
	1. If the Regional Office is the payee, who will become payee? Team will need to discuss this.
 | Date: | Completed By: | Description:  |

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| **Section B:** Initial Transition Meeting |

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| 1. Please provide a brief update as to why this transition is being held?
 | Date: | Completed By: | Description:  |
| 1. Individual provide an update about their situation and needs.
 | Date: | Completed By: | Description:  |
| 1. Who will notify the following entities of the move?
	1. Current landlord
	2. Post office
	3. Social Security Office
	4. Medicaid Office
	5. Bank
 | Date: | Completed By: | Description:  |
| 1. Who will supply the Provider with documentation of guardianship and payee?
 | Date: | Completed By: | Description:  |
| 1. Have any startup needs been identified in order for the individual to move into the home (rental/utility deposits, furniture, household set-up, etc.)? If so, has a funding source been identified prior to the move?
 | Date: | Completed By: | Description:  |
| 1. Will the individual be accessing any additional services and has UR approved those services?
	1. Examples:
		1. Day Hab Services
		2. Employment Services
		3. Specialized medical services
		4. Behavioral services
		5. Transportation
 | Date: | Completed By: | Description:  |
| 1. What will the individual’s daily routine look like?
 | Date: | Completed By: | Description: |
| 1. Does the individual qualify for Community Transition Services? See Waiver Manual.
	1. ( [Waiver Manuals | dmh.mo.gov](https://dmh.mo.gov/dev-disabilities/programs/waiver/manuals))
 | Date: | Completed By: | Description:  |
| 1. Is the new home provider owned or controlled?
 | Date: | Completed By: | Description:  |
| 1. Would remote supports be appropriate for this individual?
 | Date: | Completed By: | Description:  |
| 1. Any durable or special medical equipment utilized by the individual?
	1. Has this been approved by UR?
 | Date: | Completed By: | Description:  |
| 1. Does the individual have any special medical supplies or equipment needs and has it been approved by UR?
 | Date: | Completed By: | Description:  |
| 1. Has the receiving provider’s staff been trained on the individual’s medical support needs?
 | Date: | Completed By: | Description:  |
| 1. The Sending SC is responsible for informing the sending and receiving regional office Client Information Center (CIC). (unless individual is not changing addresses)
	1. Please refer to the transfer contact brochure if trouble locating the CIC. ([Support Coordination Transition and Transfer Contacts | dmh.mo.gov](https://dmh.mo.gov/media/pdf/support-coordination-transition-and-transfer-contacts))
 | Date: | Completed By: | Description:  |
| 1. Health Risk Screening Tool (HRST) needs completed for all individuals new to residential services.
	1. <https://dmh.mo.gov/media/pdf/hrst-process>
 | Date: | Completed By: | Description:  |
| 1. What is the date of last HRST and nursing review?
 | Date: | Completed By: | Description:  |
| 1. Date of last LOC.

 | Date: | Completed By: | Description:  |
| 1. Date of last MAAS? Current?
 | Date: | Completed By: | Description:  |
| 1. Will there be any changes to the following:
	1. Primary Care Physician
	2. Optometrist
	3. Behavioral Services
	4. Medical Specialist
	5. Psychiatrist
	6. Counselor
 | Date: | Completed By: | Description:  |
| 1. One week before the individual moves the Sending TCM will send the following documents to Receiving TCM & Provider.
	1. Current ISP, including any addendums and approved authorizations
	2. Crisis Safety Plan/Behavioral Support Plan.
 | Date: | Completed By: | Description:  |
| 1. Who will provide the following to the receiving provider no later than the day of the move:
	1. Current Physician’s orders
	2. A minimum of a 7 day supply of current medications, with plan in place for renewal
	3. Current physical, vision and dental exams
	4. Medicaid, Medicare, ID card and Social Security cards
	5. Current immunization record
	6. Adaptive equipment
	7. Current specialized medical information
	8. Information regarding diet and allergies
 | Date: | Completed By: | Description:  |
| 1. Who will transport the individual to new setting?
 | Date: | Completed By: | Description:  |
| 1. Who will arrange or transport the following items to the receiving provider?
2. Clothing
3. Personal care items
4. Personal property
 | Date: | Completed By: | Description:  |
| 1. Who is responsible for conducting the personal property inventory at the individual’s new residence? When will this be completed?
 | Date: | Completed By: | Description:  |

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| **Section 1B:** Complete only if transitioning to Shared Living and Host Home |

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| 1. For Shared Living, has the individual and/guardian been made aware of their choice in relief staff?
 | Date: | Completed By: | Description:  |
| 1. Host Home environmental site review needs completed on all new host home locations.
 | Date: | Completed By: | Description:  |
| 1. For Shared Living, is there a current MAAS report available?
	1. If not, has a MAAS (by provider) been requested?
 | Date: | Completed By: | Description:  |

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| **Section C:** Behavior/Mental Health Supports (Are there diagnoses, behaviors or history that indicate a need for increased support? If yes, this section must be covered in the transition call) |

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| 1. Summarize/discuss known behavior support needs for transition team, how will new supports meet these needs? Are there concerns?
 | Date: | Completed By: | Description:  |
| 1. SC will notify the receiving Area Behavior Analyst & RPC if the individual is moving from one of the following:
	1. Level II facility
	2. Nursing home
	3. Psychiatric hospital
	4. Jail
	5. New to residential services
	6. Or if the individual has been in a psychiatric hospital or jail within the past year
 | Date: | Completed By: | Description:  |
| 1. Has the provider received a copy of the BSP and trained all staff on specialized behavioral supports?
 | Date: | Completed By: | Description:  |
| 1. Is the receiving provider a Tiered Agency?
	1. If so, has the provider coach been informed?
 | Date: | Completed By: | Description:  |
| 1. If the individual has a Behavior Support Plan, have behavior services been secured in the new location and has the BSP been sent to the new Behavior Analyst?
 | Date: | Completed By: | Description:  |
| 1. If there are limitations to rights of this individual, how would this impact rights of any housemates?

**Note**: If housemates’ rights will be impacted, must be reviewed by receiving due process committee. If limitations are needed for transition, these are to be reviewed by sending due process committee. | Date: | Completed By: | Description:  |
| 1. Is there a current safety crisis plan in place or a need for one? If a need, who will write it?

New provider is responsible to train staff on safety crisis plan * 1. Link to the safety crisis plan template:
		1. <https://dmh.mo.gov/media/pdf/safety-crisis-plan>
 | Date: | Completed By: | Description:  |
| 1. How will mental health needs be met during transition and with new provider?
 | Date: | Completed By: | Description:  |
| 1. Are there any psychotropic PRN medications prescribed for this individual? If yes, is the protocol included in the plan? If no it must be documented before transition occurs.
 | Date: | Completed By: | Description:  |
| 1. If a disruption/delay in behavioral services is anticipated during the transition, SC will notify the Area Behavioral Analyst.
	1. If this is an emergency transition then the RPC will notify the Area Behavior Analysts.
 | Date: | Completed By: | Description:  |
| 1. If moving to a new county, has the provider informed the local Crisis Intervention Team (CIT) officer of the move?
	1. <https://www.missouricit.org>
 | Date: | Completed By: | Description:  |
| 1. If appropriate, has the DMH Area Behavior Analyst been consulted for services regarding possible gaps in care contributing to crisis events, repeated hospitalizations, or law enforcement/first-responder interactions?
	1. <https://dmh.mo.gov/media/pdf/tiered-supports-contact-list>
 | Date: | Completed By: | Description:  |
| 1. Team has discussed behavioral EMT’s that have occurred in the last 6 months (i.e. hospitalization, crisis respite stays, crisis stays, law enforcement involvement, etc.)
 | Date: | Completed By: | Description: |
| 1. If the staffing pattern is above 485 hours/month what is the plan for the individual to ultimately need less staffing?
 | Date: | Completed By: | Description:  |
| 1. Does the individual need to be supported by a staff that have crisis management training?
 | Date: | Completed By: | Description:  |
| 1. Is there a local hospital that provides psychiatric acute care? If not, where is the nearest facility?
 | Date: | Completed By: | Description:  |
| 1. Team has developed a backup plan for other potential supports needed to continue supporting the individual.
 | Date: | Completed By: | Description:  |

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| **Section 1C:** Schedule Post Move Meeting |

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| 1. Date sending SC completed the ISP.
 | Date: | Completed By: | Description:  |
| 1. Which SC will complete monitoring and review during the first 30 days after the individual moves?
 | Date: | Completed By: | Description:  |
| 1. Schedule the post move meeting with team.
 | Date: | Completed By: | Description:  |

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| **Section D:** Post Move Meeting |

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| Post Move Meeting Attendance: | Date of Post Move Meeting: |

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| 1. Please have individual/guardian and or provider give an update on the move/current status.
 | Date: | Completed By: | Description:  |
| 1. Does the individual require any changes to the home, services, supports?
 | Date: | Completed By: | Description:  |
| 1. Has the personal inventory form been reviewed and signed off by both the sending and receiving providers?
 | Date: | Completed By: | Description:  |
| 1. Receiving RO/TCM has received copies of budget, UR approval, and details of all approved authorizations (including SME, transportation units, behavioral and employment services etc. as applicable)?
 | Date: | Completed By: | Description:  |
| 1. If applicable, interdivisional (IDA) or interdepartmental agreement has been completed, signed, and copy forwarded to receiving TCM?
 | Date: | Completed By: | Description:  |
| 1. If home modifications were needed were these approved and completed, or set a completion date.
 | Date: | Completed By: | Description:  |
| 1. Sending SC to ensure that CIMOR is up to date with all accurate information (i.e. address, phone number, etc.) prior to transfer to new TCM.
 | Date: | Completed By: | Description:  |
| 1. Has the receiving provider added themselves as a DD provider Rep in CIMOR?
 | Date: | Completed By: | Description:  |
| 1. Has the Sending TCM resolved all IQMFD entries?
 | Date: | Completed By: | Description:  |
| 1. Has the Sending TCM resolved all nursing review action plans? HIPS
 | Date: | Completed By: | Description:  |
| 1. If the individual is new to residential services, has a MAAS been scheduled or completed?

  | Date: | Completed By: | Description:  |
| 1. Has the transfer acceptance date been discussed?
 | Date: | Completed By: | Description:  |
| 1. If the individual is transitioning from a state operated program, it is recommended, but not required, for the team to hold a 60-day and 90-day follow up call. Have those been scheduled?

 | Date: | Completed By: | Description:  |
| 1. An updated ISP Addendum needs to be sent to team for signatures prior to transfer of case management.
 | Date: | Completed By: | Description:  |
| 1. The completed checklist will need to be sent to the support team and transitions inbox:
	1. transitions@dmh.mo.gov
 | Date: | Completed By: | Description:  |

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| 60 Day Call Attendance/Optional: | Date:  |

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| 90 Day Call Attendance/Optional: | Date:  |

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| **Approval Signatures:** |

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Individuals Signature Date

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Parent / Legal Guardian Signature Date

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Provider Representative Signature and Agency Date

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Provider Representative Name and Agency Date