BDDS TRANSITION PLAN 10-01-10

Individual's Name:_____

Provider/Location: **From:** _____ **To:** _____

Current Address:_____

New Address: _____

Projected Transition Date:_____

****

STEPS REQUIRED BY TYPE OF TRANSITION

MARK TYPE OF TRANSITION:

Initial Transition:

☐ From Home:

- To Supported Living (5 through 25, 28 mandatory)
- To SGL (6 -15, 17-20, 23, 24, 27, 28 mandatory)

☐ From Other Settings, such as State Operated Facilities, Nursing Facilities, Children's Facilities, or Supervised Group Living Settings or Large ICF/MR Facilities (transitions from SGL or LP ICF/MR are only considered initial if the individual is moving to Supported Living):

- To Supported Living (2, 5 through 25, 27, 28 mandatory)
- To Supervised Group Living or Large ICF/MR Settings (6-15, 17-20, 23-24, 27, 28 mandatory)

Subsequent Transition:

☐ Change of Residential Service Provider:

- Change of Supported Living Provider with Change of Residence (1 through 25, 27, 28 mandatory)
- Change of Supported Living Provider without Change of Address (1 through 12, 14-18, 19, 20 through 25, 28 mandatory)

Subsequent Transition, Continued:

- Change of Supervised Group Living Residence and/or Large ICF/MR Residence (2, 6 through 12, 14, 16-20, 23-24, 28 mandatory; 13 if possible; 15 at BDDS' discretion)

☐ Change of Address (with same Residential Provider and Team) (3, 4, 6, 7, 12, 13, 15, 21-25, 28 mandatory)

☐ Change of Address (with same Residential Provider but moving to a new BDDS District) (3, 4, 6, 7, 12, 13, 14, 15, 21- 25, 28 mandatory)

☐ Transition from DD, AU or SSW to LP ICF/MR or SGL (2, 6-14, 15 at BDDS' discretion, 16-20, 23-24, 27, 28)

☐ Transition to a Nursing Facility for a long-term stay from another BDDS Residential Setting (6 through 11, 14, 16 (copy), 17, 18, 19 (copy), 20, 24, 28 mandatory)

Transition to ESN:

☐ Transitions into an ESN home from any setting, including ESN transfers (2, 6-14, 15 at BDDS' discretion, 16-20, 23-26, 27, 28 mandatory, 5 & 21 mandatory if the ESN home is state funded)

BDDS TRANSITION PLAN 10-01-10

Item	Activity	Person Responsible	Due Date	Completion Date
1. Notice of Intent to Change Provider	Pick List Signed and sent to Service Coordinator; All parties notified about change			
2. Supplemental Transition Information Form	Current provider completes the first part and sends to Service Coordinator, who has the potential provider complete the second portion. New service provider then returns it to the Service Coordinator.			
3. Lease	Copy to new Provider			
4. Individual's Living Expenses	Copies of utility bills for at least the past month and plan for paying for bills if transition occurs mid-month given to new provider			
5. Submission of New CCB and/or State Line Budget	To be submitted by CM (if CCB) or new Provider (if State Line Budget Tool)			
6. Personal Inventory	Completed; copy to new Provider			
7. Family/guardian notification/contact information	Family/guardian notified of new address and telephone number; Copy of Family/guardian contact information given to new Provider			
8. Healthcare and Other Service Provider information	All contact information to new Provider			
9. Medical appointments	Historical/collateral health information and upcoming scheduled appointments given to new Provider			
10. Transfer of Payee	If needed, Request for Change of Payee completed			
11. Income and Assets Information	Confirm type and amount of for earnings, benefits, trust funds, food stamps, HUD subsidy, and other assets for new Provider; application for benefits completed as needed			
12. Day Service Program Information	Confirm provider(s)/location(s) and transportation arrangements; discussion regarding day service plans and/or meaningful day activities			
13. Visits with Potential Housemates/to New Address	Schedule visits and arrange transportation. Confirm that all support team members for each housemate, including the individual transitioning, believe the housemate match is appropriate.			
14. High Risk Plan(s) **Risk Issues** ➢ _____ ➢ _____ ➢ _____ ➢ _____	Risk Plans in place and updated for new setting and provider. Discussion between providers held.			

15. Environmental Inspection Checklist/BDDS Pre-Transition Quality Checklist	Schedule time(s) for Service Coordinator/Case Manager to complete at new home. "Yes" responses required on items 1-21of the BDDS Pre-Transition Quality Checklist before a move is approved.			
16. ISP and BSP; 60 Days of Documentation (Progress Notes, etc.)	CM or Provider has completed appropriate updates to ISP. If applicable; BSP has been updated for new living situation; new provider has been given copies of at least the last 60 days of documentation.			
17. Medicaid Card, Soc. Sec. Card, Birth Certificate, Food Stamp Card, Other Legal Papers	Originals given to new Provider			
18. Medications and Prescriptions	Given to new Provider			
19. Community Activities	Confirm calendar of upcoming planned activities			
20. Confirm Medicaid Status and Level of Care Approval	Confirm that correct Medicaid Aid category is in place and active			
21. State Line Budget Approval	Confirm approval			
22. CCB Approval	Confirm approval			
23. Individual Specific Training for High Risk Plans, Behavior Support Plans, Health, Medical	Confirm that that the High Risk Plan(s) and/or HRC approved Behavior Plan have been established or revised, as needed, and document that individual-specific training has been completed with new direct support staff.			
24. Transition Plan	Completed; signed by Service Coordinator to give final approval for Transition, date of actual transition identified on the form; copies distributed			
25. Staffing Appropriate to Meet Health & Welfare Needs of the Individual	Confirm that the staffing schedule is appropriate to meet the individual's service needs as specified in the CCB/POC and service planner. Copies of staff schedules (including names of all direct support staff), documentation of staff training, and any other requested pertinent staff documentation must be given to the Service Coordinator prior to the move and must be attached to this form.			
26. Staff Interview to Competency	5 staff (two 1st shift, two 2nd shift and one 3rd shift) must be interviewed and show competency in the following person-specific areas: ISP/Meaningful Day, Health & Medical, High Risk Issues, Maladaptive Behaviors.			

27. Residential Approval Form	Completed and copies distributed as needed for SGL placements			
28. Freedom of Choice form	Freedom of Choice form signed by Individual, or their legal representative when indicated			

NOTES:

SERVICE COORDINATOR'S SIGNATURE INDICATES ALL ITEMS ARE COMPLETED AND THE MOVE IS APPROVED:

_____ _____ _____

Service Coordinator's Signature **Approval Date** **Actual Transition Date**

cc: Case Manager
Residential Provider
BDDS file