|  |  |  |
| --- | --- | --- |
| Transition Plan | | **CLIENT NAME:** |
| **DOB:** | **DATE OF TRANSITION MEETING** | **Residential Discharge Address:** |
| LSTC TEAM MEMBER NAME | ROLE / ORGANIZATION | CONTACT INFORMATION |
|  | Person Supported |  |
|  | Guardian |  |
|  | QIDP |  |
|  | Social Worker |  |
|  | Applied Behavior Analyst |  |
|  | Crisis Stabilization Coordinator |  |
|  | DD Program Manager |  |
|  | Nurse |  |
|  | Vocation/Education |  |
|  | Physical Therapist |  |
|  | Occupational Therapist |  |
|  | Speech Pathologist |  |
|  | Dietician |  |
|  | Life Skills Manager |  |
|  | Protection and Advocacy |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| POST DISCHARGE TEAM MEMBER NAME | ROLE / ORGANIZATION | CONTACT INFORMATION |
|  | Person Supported |  |
|  | Guardian |  |
|  | LSTC QIDP |  |
|  | LSTC Social Worker |  |
|  | Applied Behavior Analyst |  |
|  | Crisis Stabilization Coordinator |  |
|  | DD Program Manager |  |
|  | LSTC Nurse |  |
|  | Protection and Advocacy |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phase 1: What supports are needed to move to the community. | | | |
| The individual, family members, parents/legal guardians, LSTC team members, advocates and other required or requested individuals meet to explore moving the individual to the community through the PERSON-CENTERED TRANSITION PLANNING PROCESS. Step 1 can take as much time as needed to develop a Person- Centered Transition Plan that will ensure success which includes identifying community supports. This first step is to identify the needs of the client and begin to identify residential living arrangements that could meet the individual’s needs. | | | |
| BEGINNING THE PERSON-CENTERED PLANNING PROCESS  *(Sending/current provider to complete)* | **WHO** | DATE  **COMPLETED** | OUTCOMES / COMMENTS |
| Residential Decision Profile (RDP) score as been established based on the discussion of transition at most recent support plan | Person supported, Guardian, DDPM, and LSTC team | Support Plan Date: | RDP Score: |
| Individual / parents / guardians have signed an authorization to disclose information form (ADI) and receiving provider authorizations | LSTC/DDPM | Date Signed: |  |
| Assure individual financial status has been discussed | LSTC/DDPM/Guardian/Provider | Discussion Date: | MA Number:  Burial account:  Personal funds:  Savings Account:  ABLE account:  Trust fund:  SSI benefit:  Social Security: |
| Determine eligibility for entitlement programs for community living | LSTC/DDPM/Provider | Discussion Date: | Money Follows the Person:  State Deinstitutionalization Funds: |
| IDENTIFYING INDIVIDUAL SUPPORT NEEDS / DESIRES  *(Sending/current provider responsible to complete)* | WHO | DATE  **COMPLETED** | OUTCOMES / COMMENTS |
| Recommend appropriate community living model that matches the person's description (not LIMITING to but including In-Home Supports, Residential Habilitation, Independent Habilitation, ICF, Foster Care Option – also Day Habilitation, Individual Employment Support, Prevocational Services, Small Group Employment Support) through individual discussions and team meetings). | LSTC Team | Support Plan Date: | Appropriate living models: (See meeting minutes in support plan) |
| Supports Intensity Scale (SIS) assessment | Rushmore group/DDPM | Date assessment completed: | SIS Score: |
| Assemble Referral Packet to include:   * Summary of initial plan (personal description, critical components for success, and what he/she desires/needs for successful community living) * Client referral information form * Relevant records from current setting: * Medical   + Dental records   + Dietary Recommendations   + Psychological Evaluations * Risk Assessments * SP / OSP / IEP / PBSP (plan documents) * SLP / OT/ PT records and recommendations * History   + Work history / vocational assessments   + Legal status concerns (pending charges, criminal, offender, restitution)   + Guardianship findings- Letters and Orders | DDPM/LSTC | Date Information was sent: | Receiving Person:  Any other information needed? |
| IDENTIFY COMMUNITY LIVING PROVIDERS  *(DDPM responsible to complete*) | WHO | DATE  **COMPLETED** | OUTCOMES / COMMENTS |
| Region posts Therap referral | DDPM | Date referral sent: | Follow-up: |
| Person / family / guardian tours and interviews community provider | LSTC Team | Date provider accepted in Therap: | Tour(s) dates: |
| Providers will observe person in current settings and gather additional information | Accepting Provider | Date provider visits LSTC: | Names of visitors: |
| Planning Meeting with New Provider to review the Person-Centered Description and discuss what person would like / need in the community.  Topics to discuss include:   * Individual skills, and interests * Level of staff supervision * Housemate status * Health / Medical / Medications * Professional Services * Safety concerns * Methods of Positive Supports (MPS) * Relationships (staying in touch with family and friends) * Employment * Learning style / skill development | Transition Team | Discussion Date: | Discussion: |
| District to district planning for school age kids (including the provider agencies) | School districts involved: |  | Meeting dates: |
| ASSURE PROVIDER HAS FOLLOWING DOCUMENTS  *(DDPM and sending provider responsible)* | WHO | DATE COMPLETED | OUTCOMES / COMMENTS |
| Birth Certificate |  | Date Sent: |  |
| ND ID Card |  | Date Sent: |  |
| Medicaid ID Card |  | Date Sent: |  |
| Social Security Card |  | Date Sent: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phase 2: Making the transition to a new home in the community. | | | |
| The person is now working with the identified community providers and the other members of his/her team to establish collaborative relationships and to further develop the transition plan that will ensure a successful move to the community. | | | |
| COMMUNITY PERSON CENTERED TRANSITION PLAN AND ACTIONS *(Sending Agency)* | WHO | DATE  COMPLETED | OUTCOMES / COMMENTS |
| Schedule regular visits throughout this transition phase between residential provider, work / school, or other settings in new community / home | LSTC/Provider |  | Dates: |
| Identify new DDPM, if necessary, and when contact was made with individual |  |  | Current DDPM:  New DDPM: |
| Identify new guardian if corporate/agency assigned |  |  | Current Guardian:  New Guardian: |
| Housing (where, type, adaptations, environmental support, welcoming): *(DDPM and Receiving Agency)* | | | |
| • Assure Section 8 Housing application is submitted | DDPM | Date submitted: | Response? |
| • Determine necessary environmental support for home; obtain an OT evaluation for housing adaptations, if needed | LSTC/Provider | Discussion Date: | Supports: |
| • Identify and purchase household items if needed | Provider |  | Items needed: |
| Health and other professional services (identify health / medical / professional needs): *(DDPM and Receiving Agency)* | | | |
| • Medical and/or adaptive equipment needed | LSTC/ Provider | Date Discussed: | Equipment Needed: |
| • Coordination of Nursing | LSTC/Provider Nursing |  | Current Nurse:  New Nurse: |
| • Set up community pharmacy, doctor, dentist | LSTC/Provider/  Guardian | Date Discussed: | Doctor:  Dentist:  Pharmacy:  Psychiatry:  Doctor appt date:  Dentist appt date:  Psychiatry appt date: |
| • Identify other specialized health care or professional services (i.e., nutritionist, OT, PT, Speech) | LSTC/Provider | Date Discussed: | Names/Appt dates: |
| Medica information has been reviewed with provider |  |  |  |
| |  |  |  |  | | --- | --- | --- | --- | | COMMUNITY PERSON CENTERED TRANSITION PLAN & ACTIONS *(Sending & Receiving Agency)* | WHO | DATE  COMPLETED | OUTCOMES / COMMENTS | | | | |
| Behavioral and Mental Health: | | | |
| • Modifications of current behavioral supports required for implementation in new setting | LSTC/Provider | Date Discussed: | Applied Behavior Analyst: |
| • Discuss Crisis/Safety plan, if needed | LSTC/Provider | Date Discussed: | Applied Behavior Analyst:  Crisis Stabilization Coordinator: |
| Communication and choices: *(Sending Agency)* | | | |
| • Identify the communication style | LSTC | Date Discussed: |  |
| • Determine any communication materials that need to be developed for transition i.e. social stories, pictures | LSTC | Date Discussed: |  |
| • Determine assistive technology (AT) needed in new home | LSTC | Date Discussed: |  |
| Daily routines / employment / school / community involvement: *(Receiving Agency)* | | | |
| • Discuss vocational options | LSTC/ Provider | Date Discussed: |  |
| • Identify preferred community involvement/recreation activities | LSTC | Date Discussed: | Preferred recreational activities: |
| Relationships / family: *(Receiving Agency)* | | | |
| • Discuss current family involvement | LSTC | Date Discussed: | Preferred communication methods, and frequency (assure contact information has been shared): |
| • Identify family concerns | LSTC | Date Discussed: |  |
| • Has there been a loss of contact with someone important to them? (death, or a move) | LSTC | Date Discussed: |  |
| COMMUNITY PERSON CENTERED TRANSITION PLAN & ACTIONS | WHO | DATE  COMPLETED | OUTCOMES / COMMENTS |
| Finances: *(Receiving Agency)* | | | |
| • Set up community bank accounts | Provider/ Guardian |  | Name of Bank: |
| • Apply for SNAP and other benefits | DDPM/ Provider | Date Discussed: |  |
| • Reconcile and prepare finances for client in current setting being discharged from | LSTC | Date Discussed: | LSTC will keep a small amount of funds for any outstanding bills, then forwarded on to person after 30 days  Determine amount of cash needed day of move: |
| Staff support (staff needed and trained): *(Sending and Receiving Agency)* | | | |
| • Discuss staff skills/traits/characteristics desired or to be avoided | LSTC | Date Discussed: |  |
| • Provide staff training on person's plan (MPS/OSP/IEP) to the receiving provider | LSTC/Provider | Date Discussed: | Training dates: |
| • New staff spend time with person at current setting to build relationships and learn skills and personalities | LSTC/Provider | Date Discussed: | Dates: |
| Plan for the move: *(Sending & Receiving Agency)* | | | |
| Determine move date | LSTC/Provider/DDPM/Guardian | Date Discussed: | When: |
| Details regarding the move (date, time of arrival, transportation, and staff support) | LSTC/Provider/DDPM/Guardian | Date Discussed: | See Transition Schedule |
| Outlier Discussion | LSTC/Provider | Date Discussed: | Need for Outlier? |
| Inventory Lists Updated   * Seasonal items – gloves, hats, boots * Appropriate clothing (sizes, good shape, weather) * Items to be disposed of / donated * Anything in storage | LSTC |  | Staff will support individual to inventory items prior to the move. |
| • Any specific personal items restricted by team | LSTC/Guardian | Date Discussed: | What: |
| Identify any remaining concerns | LSTC/Provider/DDPM/Guardian | Date Discussed: |  |
| MOVE DAY  *(Sending agency)* |  | DATE  COMPLETED | OUTCOMES / COMMENTS |
| Final Medical Discharge Packet which includes:   * MD and Nurse Discharge Note * Supply of Medication (15 - 30 day) * Personal Money | LSTC |  | The QIDP will assure that the packet is delivered to new provider the day of transition. |

**Phase 3: Living in the community for the first 30 days.**

This phase includes adjusting and enhancing the individual’s transition plan and community supports for 30 days after the person moves.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SETTING UP, WELCOMING, AND SETTLING IN  *(Receiving agency)* | | WHO | | DATE  COMPLETED | OUTCOMES / COMMENTS | |
| * Participate in 30-day meeting * Assure closure of person’s account with sending agency | | Provider/LSTC QIDP | |  |  | |
| Discuss 24hr schedule | | Provider/LSTC QIDP | |  |  | |
| COMMUNITY PERSON CENTERED PLAN AND ACTION  *(Receiving agency)* | |  | |  |  | |
| Person, family/guardian and other team members participate in 30-day meeting to review initial plan, identify what’s working/not working, and make changes as needed. Include: | | Who should be there: | | Date of 30 day: | Sending agency participates in 30-day plan | |
| • Additional supports provided, if needed, in person or by phone | |  | | |  | |
| • Person’s / families hopes, dreams, fears | |  | |
| • Housing / environmental issues | |  | |
| • Medical / safety concerns (possibly done in conjunction with DDA Nursing Care Consultants) | |  | |
| • Employment/School (include Counties/employment providers and/or school personnel in team meetings) | |  | |
| • Relationships (developing new/maintaining old) | |  | |
| • Positive behavior supports | |  | |
| • Community inclusion/activities | |  | | |  | |
| • Communications / Assistive Technology | |  | |
| • Learning new skills | |  | |
| • Identify any needed staff training / technical assistance/additional outliers or special projects | |  | |

**Additional Contact with community Providers (transition visits, regional referral, tours, provider interest, and observation dates) listed below:**

|  |  |
| --- | --- |
| **Date** | **Comments** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| Guiding Principles for Person-Centered Transition Planning  The focal person drives the transition process.   * ***Listen carefully to the person, no matter the communication style. Honor the person's choices of what is needed and desired to be successful.*** * Base decision making on building a better and better understanding of the particular details that really matters to the person. * Build on the person's capacities, including interests and skills, and support achievable goals that build success.   Involve the person's “support network” to create a collaborative transition process.   * Identify and involve people who knows the person well, who have positive relationships, and a long history such as family members, current and past providers, and friends. * Identify the “key person” who will be involved throughout the person's transition and will help ensure the transition is successful. * Build a “support network” that works well together which includes:   o Clear and active communication and clarifying who does what;  o Flexibility when making plans so everyone can show up (i.e. staff schedules, family's available time);  o Information shared that is positive and useful, so the person's story is not lost when moving from one setting to another; and  o Expertise shared between institutional and community staff, such as doctors, direct support staff.   * Involve families and address their concerns and the supports they may need for this transition, such as, reassurance, other families who can provide advice, or professional counseling.   Develop a transition process that's realistic and ensures success.   * Start transition planning as soon as possible. * Provide helpful resources and enhancements while the person is still at the institutional setting and determine what and how those helpful supports can be translated to the community setting. * Take as much time as needed for the move to be successful while taking into consideration the benefits of moving with what's necessary to be in place before making the move. There may be additional considerations when individuals are moving across the state or to a community they don't know. * Balance attention to meeting assessed needs with actions that create new stories that grow from what becomes possible with the move.   Build community supports so the person can be an active member of the community and have positive relationships.   * Start to develop community supports, networks, relationships before the person leaves the institution that will enhance success including locating affordable housing in a safe neighborhood, working with local first responders and medical and mental health providers, identifying employment supports along with the appropriate county, developing relationships with neighbors, identifying social groups and activities available in the community. * Continue to build on these community support networks and relationships once the person moves including maintaining old and establishing new non-paid reciprocal relationships with others (family, community members, and staff), securing employment and getting involved in social groups and community activities outside of home. |