



## **Transition Plan Guidelines**

The typed transition plan should be covered in a transition meeting with representatives from the current and requested provider. The requested TCM is required to facilitate the transition and should make every attempt to ensure that an agreed upon time and place is scheduled within a reasonable timeframe. The transition plan must identify the effective date of the transition and should include a signature page of all persons present. The transition plan should be submitted to the CDDO **within three business days** of the transition meeting to allow for the review the transition plan. **If all items are not adequately addressed in the transition plan, it will be sent back to the TCM for completion before the CDDO will process it and changes are made in KAMIS.**

### ***Signatures of all members in attendance:***

1. Consumer and/or Consumer’s Guardian
2. Current Case Manager
3. Requested Case Manager
4. Current Service Provider
5. Requested Service Provider
6. MCO/Care Coordinator (if applicable)

### ***Current Staffing:***

An explanation of the current staffing schedule and what the agreed upon staffing will be from the new provider. How long can they safely be left alone at home or the community, if at all?

### ***Medical Supports:***

An explanation of the current medical supports and current health issues. List of current medications, medical providers (Primary Care Physician, Dentist, specialists, etc). Name of current pharmacy and if there will be a pharmacy change. Note how many days of medications they will be coming with and if new scripts will be needed for any medications. Explain what level of support they need with their medications, what does that look like. Do staff need to hand them their medications, do they need crushed and put in pudding, do they need help with eye drops, etc. Do they have a supply of briefs that they are bringing with them? List of all DME or adaptive equipment they need (wheelchair, walker, lift, hospital bed, blood pressure machine, glucometer, nebulizer, C-pap, etc).

### ***Financial Supports:***

An explanation of the current financial supports and issues if any. Indicate who the current Representative Payee is and if it will be transitioned to

anyone new. Explain what steps have been taken thus far to make the transition of payee. List financial resources including ABLE account or any trust the person may have set up in their name. List how much money the person can carry safely on their person. What benefits does the person have (Medicaid, Medicare, food stamps, HUD voucher, LIEAP energy assistance)? Is the paperwork, cards for all of these being transferred to the new provider?

***Behavioral Supports:***

State if the person has a Behavior Support Plan or any current restrictive interventions. When were they last approved by a Behavior Management Committee? Are there any new limitations or restrictions that need added to the PCSP?

***Moving: (Residential transitions only)***

Who is responsible for the application to the new landlord? Which provider is responsible for moving the person on move day? Who is responsible for cleaning their old living space and by when? What is the day/time they will move and the new provider is responsible for providing services? Which provider will provide transportation to their new home on the day they transition? Who will ensure they have a key to their new home?

***ADL Supports:***

Basic outline of supports needed with eating, cooking, hygiene, dressing, walking, etc.

***Miscellaneous:***

List anything additional that has been agreed upon by the new provider or important information that needs shared.

***Reason for the Transition:***

An explanation of why the consumer and/or guardian have chosen to change services. There should also be information as to how the support team has ensured that the transition was person-centered and least restrictive.

***Transition Effective Date:***

The date in which all parties agree that services will cease with the current provider and will begin with the requested provider.

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**Documents to be available for transfer at the transition meeting (at a minimum) are:**

1. Current copy of the PCSP including any outcome data generated for that particular plan.

2. Current copy of the ISP.
3. Current copy of Behavior Support Plan and/or rights restrictions and any data supporting frequency and severity of occurrence for the program year.
4. Any other behavior data accumulated for the purpose of functional assessments for the program year.
5. Guardianship and other pertinent documents (if applicable).