Individual's Name	ADSA ID Number	Move Date
Individual's Stated Transition Goal		

Developmental Disabilities Administration (DDA)

Transitional Care Management
Part C. Post Move and Stabilization

Purpose: This is a required document for any transition supported on a specialty caseload at DDA. Case Managers will use this document with each individual to support post move follow-up tasks, monitor risks for instability and ensure all supports and services are in place and meeting the needs of the individual.

C. Post Move and Stabilization

Home Address: Street | City | State | Zip Code

Two – three business days post move:

Activity	Notes
How are things going?	
How is it going unpacking and getting settled?	
Any issues or concerns with medications?	
Did ND training occur as planned?	
Any concerns identified? Any unmet needs?	

Notes

Update CARE Transition Tracking with Check-in Date:

Two weeks post move: This is a virtual meeting where the entire transition mean is invited back to check-in.
Virtual meeting date:

Activity	Notes
Attendees	
How are things going?	
How have you been spending your day?	
Have you addressed the community yet? Plans too?	
Are you getting to know your staff and housemates?	
Are you settling in and sleeping OK?	
Are you seeing any unmet needs?	
Any unmet medical protocols needed?	
Are the care needs accurately captured in the assessment?	
Overall, how does the team feel the transition has gone?	

TCU Only: PQI introduce themselves, their role. And next steps.	
Notes (include any needed follow-up)	Follow-Up Date:
Update CARE Transition Tracking with Check-in Date:	
30 days post move; plans are all in place	**Home visit date:**

Activity	Notes
How are things going in general?	
Does the individual like their room and home?	
Note if things are unpacked and organized.	
Are staff trained and comfortable meeting individual's needs?	
Review if plans are finalized and available.	
Has the individual accessed the community? Plans to do so?	
Any unmet needs?	
Follow up with provider to ensure final plans have been sent to DDA per policy at 30 days. Policy 5.08 – IISP and PBSP Policy 4.08 for NCP	

Notes (include any needed follow-up)	
Planned Follow-Up	Follow-Up Date:
Update CARE Transition Tracking with Check-in Date:	
Upon completion of the 30-day visit this form must be uploaded into RMT under Plans ➔ Transitional Care Management Quarterly plan reviews must be completed in CARE.	
CIIS, OHS, ECMP	Complete quarterly visits every 90 days and document in CARE specialized program node for CIIS, Out of Home Services, and Enhanced Case Management.
Transition, RCL, IMH, CP	Complete quarterly visits every 90 days and document in CARE plan review screen for Transition, RCL, Intensive Mental Health, and Community Protection caseloads.
Person who completed form	Contact information