INDIVIDUAL'S NAME	ADSA ID NUMBER	PROPOSED MOVE DATE
INDIVIDUAL'S STATED TRANSITION GOAL		
INDIVIDUAL'S STATED SUPPORTS NEEDED TO ACHIEVE GOAL		

DEVELOPMENT DISABILITIES ADMIISTRATION (DDA)

Transitional Care Planning Tracking
Part A. Transition Preparation

Purpose: This document is intended to be used as a facilitation guide and tracker for DDA staff coordinating a move from one setting to another. Case Managers who are facilitating care coordination meetings will use this document to track progress and highlight individual needs and readiness to transition to their identified setting. A copy will be provided to the individual and their representative to update them on transition progress as well as to transition team members as appropriate.

A. Transition Preparation: Individual requests to move to a new setting.

Transition preparation consists of the tasks that are needed to identify the individual's goals and support needs, identify preferred setting to live, and review eligibility for applicable programs. In some cases, the individual will transfer to a transition or RCL caseload or to a different office or region. The new case manager will facilitate the team meetings that occur in the ACT stage (see Part B). In these cases, the primary case manager will transfer the case after mutual acceptance has occurred between an individual and a provider after a warm handoff.

ACTIVITY	WHO	EXPECTED UPDATE	NOTES AND STATUS UPDATES	DONE	DATE
Assist to complete or update MyPage and incorporate goals into client profile	**CRM**			☐	
Review CARE with the individual and their family / guardian and ensure it is current and accurate				☐	
Discuss living options, identify preferred living arrangement, and identify appropriate community living model that matches description				☐	
Have conversation with guardian about providing needed legal documents (refer to form DSHS 10-635): • Washington State ID, • Current legal decision-making paperwork, • Social Security Card, • Insurance cards, and • Any other legal documents.				☐	
Determine financial eligibility for applicable programs	**LTC Unit**			☐	
The individual / family / guardian tours and interviews community providers	**Individual, Family, or Guardian**				
Assemble and send referral packet form and follow referral process per applicable policy.	**CRM**			☐	
For Community Residential: Region sends referral packet per policy to identified community residential provider(s) preferred by individual / family / guardian	☐ RM ☐ PQIS ☐ CRM			☐	
Providers have met the individual and guardian in the current setting				☐	
Housemates have met and agreed to live together				☐	

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Necessary environmental modifications identified				☐
DDA verified that the provider agreed to provide support to the individual, if applicable	☐ RM ☐ PQIS ☐ CRM			☐
DDA verified the individual and guardian have agreed to receive services from the provider	☐ RM ☐ PQIS ☐ CRM			☐
Mutual agreement when the individual has chosen a provider to meet their care needs and the provider agrees to provide care				☐
Referral to NCC and/or Clinical team if high acuity	**CRM**			☐

Warm Handoff: Sending and receiving CRMS (if transitioning to a new CRM) work with the individual and guardian, as well as the current and future provider to review the individual's goals, understand their support needs and create the transition team. This may be multiple meetings, depending on the circumstances. The case manager identifies the team members who will attend the initial transition meeting during the ACT stage to develop the care plans that will support the client. The initial meeting marks the beginning of the Active Coordinator of Transition (ACT) stage.

- Review Policy 3.02 for instructions on case transfer and interoffice / interregional moves.

Sending CRM:	Receiving CRM:	Date:
Meet with current and new provider and case manager(s) and ensure new residential provider has copies of all relevant documents on the DSHS 10-635 checklist. Document missing items. Identify transitional care coordinator team members.		Date: ☐ Completed ☐ Provider Declined

Please describe how the individual and their guardian or representative would like to participate in the meetings and receive updates about the transition status: