

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



DEVELOPMENT DISABILITIES ADMINISTRATION (DDA)

## Transitional Care Planning and 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			<input type="checkbox"/>	
Review CARE with the individual and their family / guardian and ensure it is current and accurate				<input type="checkbox"/>	
Discuss living options, identify preferred living arrangement, and identify appropriate community living model that matches description				<input type="checkbox"/>	
Have conversation with guardian about providing needed legal documents (refer to form DSHS 17-345): <ul style="list-style-type: none"> <li>Washington State ID,</li> <li>Current legal decision-making paperwork,</li> <li>Social Security Card,</li> <li>Insurance cards, and</li> <li>Any other legal documents.</li> </ul>				<input type="checkbox"/>	
Determine financial eligibility for applicable programs	LTC Unit			<input type="checkbox"/>	
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			<input type="checkbox"/>	
For Community Residential programs: Region sends Provider Referral Letter for Residential Services form 10-232 with attachments per applicable policy to identified residential services provider(s) preferred by individual / family / guardian	<input type="checkbox"/> RM <input type="checkbox"/> PQIS <input type="checkbox"/> CRM			<input type="checkbox"/>	
Providers have met the individual and guardian in the current setting				<input type="checkbox"/>	
Housemates have met and agreed to live together				<input type="checkbox"/>	

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Necessary environmental modifications identified			<input type="checkbox"/>
DDA verified that the provider agreed to provide support to the individual, if applicable	<input type="checkbox"/> RM <input type="checkbox"/> PQIS <input type="checkbox"/> CRM		<input type="checkbox"/>
DDA verified the individual and guardian have agreed to receive services from the provider	<input type="checkbox"/> RM <input type="checkbox"/> PQIS <input type="checkbox"/> CRM		<input type="checkbox"/>
Mutual agreement when the individual has chosen a provider to meet their care needs and the provider agrees to provide care			<input type="checkbox"/>
Referral to NCC and/or Clinical team if appropriate			<b>CRM</b>
<p><b>Warm Handoff:</b> 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.</p> <ul style="list-style-type: none"> <li>Review Policy 3.02 for instructions on case transfer and interoffice / interregional moves.</li> </ul>			
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. Ensure family has completed required agreements for participation in CIIS or OHS. Document missing items. Identify transitional care coordinator team members.			Date: <input type="checkbox"/> Completed <input type="checkbox"/> 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:			