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

Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENT DISABILITIES ADMIISTRATION (DDA)

Transitional Care Planning Tracking
Part A. Transition Preparation

Purpose: This is a required document intended to be used as a facilitation guide and tracker for DDA staff coordinating a move from one setting to another. Case Managers facilitation transitional care coordination meetings will use this document with each meeting 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 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 's goals and support needs, identify 's preferred setting to live, and review eligibility for applicable programs. 's primary case manager works to begin transition planning. In some cases the individual will transfer to a transition or RCL caseload. 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	DUE DATE	NOTES AND STATUS UPDATES	DONE DATE
Review existing available supports with / family / guardian				☐
/ family / guardian tours and interviews community providers				☐
assist to complete or update MyPage and incorporate into client profile				☐
Discuss living options and identify preferred living arrangement and identify appropriate community living model that matches 's description				☐
Determine financial eligibility for applicable programs				☐
Review CARE and ensure it is current and accurate				☐
Assemble and send referral packet form and provider level to residential referral inbox and follow referral process per policy				☐
Consent forms signed to share information				☐
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.				☐
Region sends referral packet with five (5) business days to identified community residential provider(s) preferred by / family / guardian				☐
Providers meet in current setting; gather additional information				☐

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Location of the home has been identified				☐
CRMs for and housemates have discussed compatibility of individuals				☐
Housemates met and agreed to live together				☐
Necessary environmental modifications identified				☐
RM verified that the provider agreed to provide support to				☐
CRM verified / guardian have agreed to receive services from the provider				☐
Ensure that needed ETR requests for rate adjustments are submitted				☐
LTC notified of tentative move date and eligibility confirmation has been requested				☐
Mutual agreement when has chosen a provider to meet their care needs and the provider agrees to provide care				☐

Warm Handoff: Sending and receiving CRMS (if transitioning to a new CRM) work with 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. The case manager convenes the initial meeting to develop the transition plan. The initial meeting marks the beginning of the Active Coordinator of Transition (ACT) stage.

- If cross-regional move, schedule internal DDA meeting with case managers and region to ' needs.

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 **(warm handoff)**.		Date:
Please describe how the individual and their guardian or representative would like to participate in the meetings and receive updates about the transition status:		