CLIENT'S NAME (FIRST, LAST)	ADSA ID	DATE OF BIRTH

Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Out of Home Services (OHS) Transition Checklist

The intent of this form is to provide a comprehensive overview to act as a guide in the planning process for a client's transition into out-of-home services. Write a Service Episode Record (SER) each step within this process.

FUNDING SOURCE

☐ CORE Waiver ☐ Non-waiver ☐ Road to Community Living (RCL)

Out of Home Services Team Members for Transition

Asterisk (*) indicates **required** members of the transition team.
Verify all contact information placed below is up-to-date in collateral contacts in CARE.

PARENT / GUARDIAN*	PHONE NUMBER	EMAIL
PARENT / GUARDIAN	PHONE NUMBER	EMAIL
CURRENT CASE RESOURCE MANAGER*	PHONE NUMBER	EMAIL
CURRENT SUPERVISOR	PHONE NUMBER	EMAIL
RECEIVING CASE RESOURCE MANAGER*	PHONE NUMBER	EMAIL
RECEIVING SUPERVISOR	PHONE NUMBER	EMAIL
RESOURCE MANAGER*	PHONE NUMBER	EMAIL
OUT OF HOME SERVICES (OHS) PROVIDER*	PHONE NUMBER	EMAIL
MANAGED CARE ORGANIZATION (MCO) CARE COORDINATOR	PHONE NUMBER	EMAIL
SCHOOL REPRESENTATIVE	PHONE NUMBER	EMAIL
BEHAVIORAL SUPPORT PROVIDER (I.E., ABA)	PHONE NUMBER	EMAIL
MENTAL HEALTH PROVIDER (I.E., WISe)	PHONE NUMBER	EMAIL
OTHER	PHONE NUMBER	EMAIL
OTHER	PHONE NUMBER	EMAIL
OTHER	PHONE NUMBER	EMAIL

Request for Out of Home Services – See DDA Policy 4.10

TASK	RESPONSIBILITY	DATE COMPLETED	COMMENTS
Staff initial request for OHS internally with OHS coordinator and supervisor			

CLIENT'S NAME (FIRST, LAST)	ADSA ID	DATE OF BIRTH

Review programmatic eligibility requirements	OHS Coordinator		
Review OHS request with family	OHS Coordinator		
Request for Children's Residential Services Signed, DSHS 10-277	Parent / Guardian		
Verify funding source for OHS (CORE Waiver or RCL)	OHS Coordinator		
Referral Process – See DDA Policy 4.21			
TASK	RESPONSIBILITY	DATE COMPLETED	COMMENTS
Completed referral packet for OHS outlined in DSHS 27-057 and submitted to OHS resource manager			
Make a plan with parent or legal guardian to apply for SSI/SSA, if not already in receipt of funding			
Send referral to providers and update referral tracking database.	OHS Resource Manager		
Identify prospective providers who have expressed interest in supporting the client and provide list to assigned CRM	OHS Resource Manager		LIST PROVIDERS
Identify environmental modifications, accessibility needs, and/or durable medical equipment (DME) prior to provider acceptance			
Prospective providers have made contact with family			LIST IN ORDER FAMILY PREFERENCE (IF MULTIPLE AGENCIES INVOLVED)
Verify mutual acceptance with provider	OHS Resource Manager		
Verify mutual acceptance with family	Assigned CRM		
Review and complete OHS acknowledgement, DSHS 09-004C			
Discuss the need for client evaluation hours per DDA Policy 6.22			
Coordinate transition meeting after mutual acceptance	Assigned CRM or SSS		
Transition Meeting			
This section is to guide the transition meeting prior to the client moving into out-of-home services using a person-centered approach. Review and complete every box during the transition meeting, if applicable to client's needs.			

CLIENT'S NAME (FIRST, LAST)	ADSA ID	DATE OF BIRTH

TASK	RESPONSIBILITY	DATE COMPLETED	COMMENTS
Discuss client's personal considerations and preferences, such as: • Strengths • Likes and dislikes • Cultural considerations • Preferred / sentimental items			
Identify a move date			
Plan day of move details, such as: • Transportation • Moving of personal items			

Support planning for physical health needs:
• Significant medical supports
• Primary physician identified
• Date of last doctor visit: _____
• Scheduled appointments in the next six months
• Durable Medical Equipment (DME)
• Provider recommendations
• Review medical protocols and staff training needs, i.e. for seizure, repositioning, etc.
• **Dentist**
  • Date of last dentist visit: _____
• **Optometrist**
  • Date of last optometrist visit: _____			

Identify if nurse delegation is needed and coordinate delegation referral			
Medication • Review current medications • Date of last medication review with prescriber: _____ • Identify medication needed upon arrival • Identify pharmacy			

CLIENT'S NAME (FIRST, LAST)			ADSA ID	DATE OF BIRTH
Support planning for behavior health needs: • Review current behavior support plans • Identify therapeutic equipment • Review current providers • Review recommendations for behavioral health that the client currently is not accessing • Identify staff training for behavior support plans				
Medical and Behavioral Health Benefit: • Identify coverage through private insurance and Managed Care Organization (MCO). If MCO verify coverage in the county the client will be residing in • Identify care coordinator				
Educational Plan: • Review Individualized Education Plan (IEP) • Identify school • Review transportation • Identify enrollment process				
Specialized dietary needs, for example: specific diet, food allergies, and/or preferred foods				
Plan for environmental modifications, accessibility needs, and/or Durable Medical Equipment (DME)				
Plan for use of restrictive procedures per DDA policy 5.20				
Verify the transfer of: • Photo ID (School or WA State ID) • Physical and Behavioral Health Card (can be photo copy)				
Review progress of SSI/SSA application process, if not in receipt of SSI/SSA				

CLIENT'S NAME (FIRST, LAST)	ADSA ID	DATE OF BIRTH

Identify a payee			
Schedule child and family engagement plan meeting	SSS		
Prior to Client Moving			
TASK	RESPONSIBILITY	DATE COMPLETED	COMMENTS
Assessment updates: • Transition client onto funding source (CORE or RCL) • Update Person Centered Service Plan (PCSP) with OHS • Provide a copy of the signed PCSP to provider • Submit DSHS 15-345 to Long Term Care (LTC) in accordance with MB D20-003 • Input new service RAC	Sending CRM		
Complete child and family engagement plan prior to client moving per WAC 388-826-0041	SSS		
Review progress of SSI/SSA application process, if not in receipt of SSI/SSA	SSS or Assigned CRM		
Send OHS prior approval	OHS Coordinator or designee		
Resource Management: • Set up rate setting with agency; Date: _____ • Send rates for regional and HQ approval prior to client starting OHS per Policy 6.22 • If applicable, review and process client evaluation hours per Policy 6.22 • Enter first authorization for service	OHS Resource Manager		
Post Move-in			
TASK	RESPONSIBILITY	DATE COMPLETED	COMMENTS
Ensure that the Individualized Instruction and Support Plan (IISP) is in place within 30 days after the client moves into program per WAC 110-145-1725	SSS		

CLIENT'S NAME (FIRST, LAST)			ADSA ID	DATE OF BIRTH
Review behavior support documents within 60 days per Policy 5.19	SSS			
For clients who move into service without being in receipt of SSI/SSA, once they begin to receive SSI/SSA submit 15-345 to notify Long Term Care (LTC) of the change in accordance of MB D20-003	SSS			
Schedule first 90 day visit in accordance with WAC 388-826-0070				