| CLIENT’S NAME (FIRST, LAST) | ADSA ID | DATE OF BIRTH |
| --- | --- | --- |
|  |
|  |  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 |  |  |  |
| Review programmatic eligibility requirements | OHS Coordinator |  |  |
| Review OHS request with family | OHS Coordinator |  |  |
| Request for Children’s Residential Services Signed, DSHS [10-277](http://forms.dshs.wa.lcl/) | 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](http://forms.dshs.wa.lcl/) 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](http://forms.dshs.wa.lcl/) |  |  |  |
| 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.  |
| 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
 |  |  |  |
| 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 |  |  |  |
| 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](https://app.leg.wa.gov/wac/default.aspx?cite=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](https://app.leg.wa.gov/wac/default.aspx?cite=110-145-1725) | SSS |  |  |
| 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](https://app.leg.wa.gov/wac/default.aspx?cite=388-826-0070) |  |  |  |