| 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) | |  |  |  | |