JOHNSON COUNTY KANSAS
Community Developmental Disabilities Organization

Transition Meeting Checklist

INSTRUCTIONS:

A Transition Meeting should occur prior to an individual starting services with a chosen service provider. Ideally, the current Targeted Case Manager will facilitate the transition meeting and is the lead coordinator for any transition which includes: *transferring from one service provider to another, moving from an institutional placement to community services, transferring from another CDDO area, or initiating services due to approval of access to the I/DD Waiver*. ***For Institutional Transfers and Ports, the CDDO QA Staff will review for Licensed Services prior to the transition/move.***

The Transition Meeting is to ensure any changes in service are planned for and implemented in a timely, well thought out manner and that all pertinent information is shared with the new service provider(s). For service transfers, both the current service provider and the new service provider must attend the meeting.

Name of Individual Served: _____

SERVICE INITIATION/TRANSFER

Date: _____ Time: _____

TCM Hours Used: _____ TCM hours Remaining: _____

Last day current Provider to bill: _____ First day new Provider to bill: _____

Billing for new Residential Provider starts the day the person served wakes up in the new Provider's services/new home

New Address (or N/A): _____

Other Contact Information

Guardian Name: _____

Address: _____

Phone: _____ Email: _____

Payee Name: _____

Address: _____

Phone: _____ Email: _____

CURRENT PROVIDER MUST SUPPLY COPIES OF ALL RELEVANT DOCUMENTATION TO NEW PROVIDER

DOCUMENTS	Yes	No	N/A	Notes
Current PCSP & Addendums	☐	☐	☐	
Current ISP	☐	☐	☐	
Current BSP, Restrictive Interventions/Psychotropic Medication Consents/ Behavior Tracking Sheets	☐	☐	☐	List Required Behavioral Supports:
Mental/Behavioral Health History, Next Steps with Mental Health Providers, Intakes & Appointments Scheduled	☐	☐	☐	
Current Risk Assessments	☐	☐	☐	
Current IEP	☐	☐	☐	
Current BASIS/Functional Assessment	☐	☐	☐	
All BASIS Data collected since last Assessment	☐	☐	☐	
Current Health Assessment, Physical or Health Profile	☐	☐	☐	
Copy of Physician/nursing orders/notes for a medical condition being monitored	☐	☐	☐	
Special Needs (dietary, OT, PT, Seizures, etc.)	☐	☐	☐	
Legal Documents (Court orders, Probation, CINC Petitions, etc.)	☐	☐	☐	
History of Legal System	☐	☐	☐	
Are they Child in Need of Care?	☐	☐	☐	
Transition Plan from DCF	☐	☐	☐	

Address change with Post Office and other relevant entities	☐ ☐ ☐	

DISCUSSION ITEMS

	Yes	No	N/A	Notes
Adaptive Equipment (walker, wheelchair, communication device…)	☐	☐	☐	
Supports needed for Medication Administration	☐	☐	☐	
Pharmacy (Must be determined/established before individual can move)	☐	☐	☐	
List of current medications/MARs /side effects	☐	☐	☐	
Special Dietary Needs	☐	☐	☐	
Allergies	☐	☐	☐	
Special Health Protocols (seizures, bruises, diabetes, etc.)	☐	☐	☐	
Previous Hospitalizations (PRTFs, Medical/Psychiatric Hospitalizations, Surgeries)	☐	☐	☐	
Out of Home Placements (PRTFs, Jail, Foster Care)	☐	☐	☐	
History of Elopement	☐	☐	☐	

Medical/Medication/Adaptive Equipment/Special Needs

Doctor/Specialist Info:

Name	Specialty	Address	Phone	Frequency/Future Appointment Dates

Residential Supports (if applicable)

	Yes	No	N/A	Notes
Alone Time	☐	☐	☐	
Supports needed for personal hygiene	☐	☐	☐	
Supports needed for clean and safe environment	☐	☐	☐	
Supports needed with laundry	☐	☐	☐	
Supports needed for dressing	☐	☐	☐	
Supports needed for transportation	☐	☐	☐	
Personal belongings and property identified for moving	☐	☐	☐	

Work/Day Supports

	Yes	No	N/A	Notes

Set schedule for day or work	☐	☐	☐	
Medication during the day	☐	☐	☐	
Support for money handling	☐	☐	☐	
Multiple DS providers	☐	☐	☐	

Money Management

	Yes	No	N/A	Notes
Payee	☐	☐	☐	
Benefits/Income (SSI, SSDI, Food Stamps, wages, etc.)	☐	☐	☐	
Personal bank account	☐	☐	☐	
Weekly personal spending amount	☐	☐	☐	
Supports needed for purchasing personal items	☐	☐	☐	
Food Benefit Card	☐	☐	☐	
Section 8 housing	☐	☐	☐	
Lease agreement	☐	☐	☐	
Utilities (electric, water, gas, cable, phone/internet)	☐	☐	☐	
Keys for apartment/house/mailbox	☐	☐	☐	

Social/Community/Natural Supports

	Yes	No	N/A	Notes
Supports needed for socializing	☐	☐	☐	

Supports needed for specific fears	☐ ☐ ☐	
Supports needed for relationships/sexuality	☐ ☐ ☐	
History with law enforcement	☐ ☐ ☐	
Involvement in specific activities (special Olympics, religious	☐ ☐ ☐	
Supports needed for communication with natural support network	☐ ☐ ☐	

Additional Comments or Notes:

PARTICIPANT SIGN IN & SIGNATURE SHEET

*Targeted Case Manager, New Providers, and Previous Providers (i.e. PRTFs, State Hospital, Rehabilitation Facilities, etc.) understand successful transitions are the responsibility of the entire support team.

DATE	NAME	SIGNATURE	AGENCY

Reviewed by QA Staff (if applicable)

Signature and Date

Signature and Date