NEW MEXICO
Department of Health
Developmental Disabilities Supports Division

DDSD Individual Transition Plan

Checklist

This checklist was created to standardize transition procedures for the Developmental Disabilities Waiver, Medically Fragile Waiver, Mi Via Waiver and Supports Waivers. The checklist will be used during transition meetings to facilitate conversations about individual health and safety needs before, during and after transitions. This form must be completed by the current Case Management, Consultant, Community Supports Coordinator or Registered Nurse Case Management agency who facilitates the transition meeting.

Date of form Completion:

Person Completing this form (discharging agency):

Contact information: Email: **Phone Number:**

Title of person completing this form (Case Manager/Community Support Coordinator/Consultant Agency/Registered Nurse Case Manager):

Type of Transition: Select

Individual's Communication Preference (i.e., phone, email, in-person): Select

Individual Identification Information:

Name:	Date of Birth (DOB):
Social Security Number (SSN):	Phone Number:
Email Address:	Category of Eligibility: Select
Address:	
MCO: Select	MCO Care Coordinator:
Current Region/County (if applicable): Select	New Region/County (if applicable): Select
Current Waiver (If participant is currently covered under Supports Waiver, please indicate if it is agency based or self-directed): Select	Date of Transition:
Current Provider: Contact Person: Email: Phone number:	Receiving Provider: Contact Person: Email: Phone number:
Description of the individual's transition situation and any unique or special considerations and/or issues that require further clarification:	

Documents required for successful transition:

***This section identifies any documents that are required to be transferred from the discharging agency to the receiving agency. If documents are not applicable, please indicate with "NA". If documents are required but are not able to be transferred, please provide detailed information on when the receiving agency can expect the documents and who will be responsible for sending the documents to the receiving agency.**

Document(s)	Y/N/NA	Title/Date of Document	Pending or not yet obtained, who will be responsible for obtaining	Date Received	Proposed date of document transfer
Current Year Assessments	Select				
Level of Care (LOC)	Select				
Individual Service Plan (ISP)/Service Support Plan (SSP); attached documents & ISP/SSP & budget revisions	Select				
Current Approval Letter from Income Support Division	Select				
Meeting notes and correspondence as available	Select				

Document(s)	Y/N/NA	Title/Date of Document	Pending or not yet obtained, who will be responsible for obtaining	Date Received	Proposed date of document transfer
Medical Reports/History & Physical and Immunization Record	Select				
List of current medications	Select				
Recent Comprehensive Aspiration Risk Management Plan	Select				
Other evaluations	Select				
Current Individual Education Plan	Select				
Division of Vocational Rehabilitation Plan	Select				
Private Duty Nursing Plan	Select				

Document(s)	Y/N/NA	Title/Date of Document	Pending or not yet obtained, who will be responsible for obtaining	Date Received	Proposed date of document transfer
Allocation Letter/Waiver Change Form(s)/SFOC (for provider changes)	Select				
Guardianship/Power of Attorney Paperwork	Select				
Employer of Record Information form or will an Employer of Record be needed?	Select				
One full year of monthly and quarterly update forms and consultant/Case Management/Community Support Coordinator Agency case notes (narratives) **(Previous quarter case notes from Med Frag Registered Nurse Case Manager)**	Select				

Document(s)	Y/N/NA	Title/Date of Document	Pending or not yet obtained, who will be responsible for obtaining	Date Received	Proposed date of document transfer
Current Living Care Arrangement	Select				
Copy of personal belongings inventory	Select				
Copy of Assistive Technology inventory	Select				
Family Living Home Study	Select				
Do not Resuscitate (DNR) Do not Intubate (DNI) and advanced directives	Select				
Birth certificate, SS card, Medicaid/Medicare card, ID card	Select				
Other pertinent information	Select				
In-Home Assessment (Vineland)	Select				

***This section facilitates important discussions that help identify any needs that ensure a successful transition. This section is not to replace the ISP/SSP. If discussion questions prompt any action items (i.e., yes answer to discussion questions), details must be included to indicate planned remediation.**

Discussion Questions	Y/N/NA	Discussion details. Identify any follow up if needed and who is responsible for completion and when. If applicable, indicate if ISP/SSP has been updated.	Date of Discussion
Therap Discharge and Transfer needed?	Select		
Are any Assistive Technology, Environmental Modifications or adaptive equipment needs identified?	Select		
Are any Crisis Supports needed?	Select		
Are any trainings needed to support the individual prior to transition?	Select		
Are any eligibility needs identified and planned for? (i.e., Medicaid eligibility)	Select		

Discussion Questions	Y/N/NA	Discussion details. Identify any follow up if needed and who is responsible for completion and when. If applicable, indicate if ISP/SSP has been updated.	Date of Discussion
Is the individual moving to a new home? Indicate if a visit to the new home has been completed.	Select		
Are new housemates identified and planned for?	Select		
Is the transfer for personal belongings planned? Move Date:	Select		
Are any revisions needed for the Individual Support Plan/Service Support Plan and budget? (e.g., new services, goals, etc.)	Select		
Is the participant currently working or wants to work?	Select		
Are there any Regional Office Request for Assistance (RORA) or Abuse Neglect and Exploitation reports pending?	Select		

Discussion Questions	Y/N/NA	Discussion details. Identify any follow up if needed and who is responsible for completion and when. If applicable, indicate if ISP/SSP has been updated.	Date of Discussion
Are there any routine or non-routine schedule/appointments needing follow through?	Select		
Does this transition identify any safety concerns?	Select		
Are there any transportation needs related to the transition? (i.e., Coordination, learning new routes, etc.)	Select		
Are there any concerns with the new service setting following the CMS Final Rule, HCBS Settings Requirements, as applicable?	Select		

Transition Meeting Attendees:

*In this section list all individuals that attended the transition meeting. If the individual identified below is a discharging or receiving provider, please include the signature. Electronic signatures are accepted. If Adobe Acrobat is not available to complete the electronic signature, a wet signature will be accepted. This signature is to confirm all parties have agreed upon the transition meeting, date, and the transfer of records from the previous agency has occurred.

Name	Role	Discharging Agency/ Receiving Agency

Signature for Current Agency **Signature of New Agency**

Below, are additional signature lines if transition includes multiple service providers:

Signature for Current Agency **Signature of New Agency**

Signature for Current Agency **Signature of New Agency**

Signature for Current Agency **Signature of New Agency**

Signature for Current Agency **Signature of New Agency**

Signature for Current Agency **Signature of New Agency**