South Carolina Department of Disabilities and Special Needs

DDSN REGIONAL CENTER INDIVIDUAL TRANSITION CHECKLIST

General Information (completed by DDSN Regional Center staff)

Name:_____

Social Security Number:_____ Date of Birth:_____

DDSN Regional Center/Residence Currently Living In:_____

Current DDSN Regional Center Qualified Intellectual Disability Professional:_____

Previous Community Supports Received (*if applicable*):

Date(s):_____ Provider(s):_____

Reason(s) for Return to DDSN Regional Center: _____

Community Service Preparations (completed by community service provider staff)

Proposed Community Residential Service Provider:_____

Proposed Community Day Service Provider:_____

Proposed Community Case Management Provider:_____

Overnight visits to new home occurred (*dates*):_____

Residential/Day Direct Support Staff Observed Individual at DDSN Regional Center (*dates*):_____

Actions Taken to Address Barriers to Successful Community Living (*if applicable*):_____

Daily Activity Schedule Developed: ☐Yes ☐No Special Diet Developed (*if applicable*) ☐Yes ☐No

Specialized Training Received (*dates if applicable*):

Nurse:_____ Behavior Support Provider:_____ Program Coordinator:_____

Medical/Therapy Provider Identified (*Name if applicable*):

MD:_____ Dentist:_____

Pharmacist:_____ PT:_____

Other:_____

Environmental Modifications Completed (*if applicable*) ☐Yes ☐No

Adaptive Equipment Available (*if applicable*): ☐Yes ☐No

Support Plan Developed: ☐Yes ☐No Waiver Slot Allocation Requested (if applicable): ☐Yes ☐No

Freedom of Choice Form Completed (*if applicable*) ☐Yes ☐No

Level of Care Form Completed (*if applicable*): ☐Yes ☐No

I attest that the above information is a correct reflection of the preparations which have been completed to facilitate the transition of the named person. I believe that all necessary preparations have been made to allow for the successful transition of this person.

_____ _____ _____ _____

CEO/Residential Service Provider Date CEO/Day Service Provider (*if different*) Date

_____ _____

CEO/Case Management Provider (*if different*) Date

DDSN Regional Center Preparations (completed by DDSN Regional Center staff)

Behavior Support Plan/Data Updated & Filed: ☐Yes ☐No Medical Records Updated/Filed: ☐Yes ☐No

Two Week Supply of Drugs/Supplies/Nutritional Supplements Packed (if applicable): ☐Yes ☐No

Clothing/Personal Possessions Inventories/Packed: ☐Yes ☐No

I attest that the above information is a correct reflection of the preparations which have been completed to facilitate the transition of the named person. I believe that all necessary preparations have been made to allow for the successful transition of this person.

_____ _____

Facility Administrator/DDSN Regional Center Date

DDSN Review

☐Transition Approved ☐Transition Disapproved

Reason for Disapproval (*if applicable*):_____

_____ _____

DDSN Regional Representative Date