South Carolina Department of Disabilities and Special Needs
DDSN REGIONAL CENTER INDIVIDUAL TRANSITION CHECKLIST

General Information (Completed by DDSN Regional Center Staff)

Name:_____ SSN:_____ DOB:_____

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 Previous Return to DDSN Regional Center (*if applicable*):_____

Community Service Preparations (Completed by Community Service Provider Staff)

Proposed Community Residential Service Provider:_____

Proposed Community Day Service Provider:_____

Waiver 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 Completed (*if applicable*): ☐Yes ☐No

Level of Care 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 and 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.

_____ Date:_____

Facility Administrator/DDSN Regional Center

DDSN Review

☐Transition Approved ☐Transition Disapproved

Reason for Disapproval (*if applicable*):_____

_____ Date:_____

DDSN District Director