

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 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 District Director

Date