Transition of Services Form

Please return this completed/signed form to the CDDO (Rikki) prior to the transition date.

Individual Transferring:	**Social:**
Current TCM:	**Current TCM Phone:**
Care Coordinator:	**CC Phone:**
Individuals Guardian/DPOA:	**Guardian Phone/DPOA:**
Individuals Payee:	**Payee Phone:**

	Services being changed	Current Provider	New Provider	Start Date of New Service(s):
☐	**Day Services**			
☐	**Residential Services**			

Income Information

Social Security Income: $_____

Employment Income: $_____

Food Stamps: $_____

Other Income:_____ $_____

TOTAL MONTHLY INCOME: $_____

Expenses Information

Client obligation/Spend Down: ☐ NO ☐ YES $_____

Monthly Out of Pocket Medical Expenses (if applicable): $_____

Recreational Expenses: $_____

Day Service Total Expenses (figured below): $_____

Residential Total Expenses (figured below): $_____

Other expenses: _____ $_____

TOTAL MONTHLY EXPENSES: $_____

Documents Provided to new Provider by TCM:

☐ Current PCSP & Addendums

☐ Current Psychotropic Medication Plan

☐ Current Functional Assessment/BASIS

☐ Behavior Data Collected in the last year

☐ Guardianship/DPOA/Conservator Papers

☐ Social Security Card

☐ I/DD Application

☐ Current Medical Records/Physician's Orders

☐ Current Behavior Support Plan/Risk Assessment

☐ Current IEP

☐ Current ISP/Funding Plan

☐ Incident Reports in the last year

☐ Birth Certificate & ID

☐ Medical Card(s)

☐ Psych Evals/Eligibility Information

☐ Any Legal/Court Papers

Day Service Supports

Transportation fees with new provider: $_____
Activity fees with new provider: $_____
Other fees with new provider:_____ $_____
TOTAL DAY SERVICE EXPENSES: $_____

Are there outstanding fees due to the current Day Provider? ☐ NO ☐ YES
If yes, for what expenses and total amount due:_____ $_____
How will these fees be paid in full to the current provider: _____
_____

Day Service Schedule: _____
Transportation Provided by:_____
Contact Person:_____ Phone:_____

Day Service (2) Schedule:_____
Transportation Provided by:_____
Contact Person:_____ Phone:_____

Work/Employment Schedule:_____
Transportation Provided by:_____
Contact Person:_____ Phone:_____

Volunteer Schedule:_____
Transportation Provided by:_____
Contact Person:_____ Phone:_____

Is there any individual alone time in the community: ☐ NO ☐ YES _____
Does the individual have their own phone during the day: ☐ NO ☐ YES
Does the individual carry their own money during the day: ☐ NO ☐ YES $_____
Does the individual disburse any of their own meds during the day: ☐ NO ☐ YES
Medication:_____When:_____

Mental Health Supports

Mental Health Diagnosis:_____
_____

Mental Health Provider:_____ Location:_____
Upcoming Mental Health Appointments:_____

Is there a Behavior Plan in place currently? ☐ NO ☐ YES
Is there a Risk Assessment in place currently? ☐ NO ☐ YES
History of involvement with law enforcement? ☐ NO ☐ YES
When:_____ Reason:_____

Specialized Supports required due to court orders/probation: ☐ NO ☐ YES
Explain:_____

Medical Supports

Medical Diagnosis:_____
_____

Medications (List/MAR provided to new provider at the time of meeting): ☐ NO ☐ YES

Current PCP:_____Location:_____
Upcoming appointments with PCP:_____Reason:_____

Specialists: _____ Location:_____
Upcoming appointments with Specialists:_____ Reason:_____

MedicationProvider/Pharmacy:_____Location:_____
Transferring pharmacy's? ☐ NO ☐ YES Date:_____
Who will be responsible for setting up transfer to the new Pharmacy? _____

Lead Medical Provider:_____ Phone:_____

Specialized medical needs/supports:_____
_____

Specialized medical equipment: _____
_____

Specialized dietary needs:_____

Allergies:_____

Special health protocols (seizure, blood pressure, diabetes):_____
_____

Previous hospitalizations or surgeries:_____

Leisure/Community Activity Supports

Religious Activities: ☐ NO ☐ YES Where:_____

Special Olympics: ☐ NO ☐ YES Where:_____
When:_____
Physical up to date: ☐ NO ☐ YES

Holiday Activities:_____
Preferred Activities:_____
Any community restrictions?_____

Residential Service Supports

Room/Board expenses with new provider: $_____

Transportation fees with new provider: $_____

Food expenses with new provider: $_____

Other expenses with new provider:_____ $_____

Has a lease/rental agreement been signed with the new provider? ☐ NO ☐ YES

Is this a Section 8/Hud home? ☐ NO ☐ YES

Application completed? If no, when and by who:_____ ☐ NO ☐ YES

What is the new residential address and phone? _____

_____

_____

Has a change in address been made to the post office? ☐ NO ☐ YES

Has a change in address (3161) been made to the State? By who:_____ ☐ NO ☐ YES

Will the individual need new items for the new home? ☐NO ☐ YES

Will funding be needed to assist with the cost of purchasing new items? ☐NO ☐ YES

If yes, who will assist with applying for funding and shopping for the new items? _____

Who will handle the packing, moving and cleaning? _____

_____

Are there outstanding fees due to the current Provider? ☐ YES ☐ NO

If yes, for what expenses and total amount due: _____

How will these fees be paid in full to the current provider? _____

Current Provider Signature	Title	Date
New Provider Signature	Title	Date
Care Coordinator Signature		Date
Targeted Case Manager Signature		Date
Guardian/DPOA Signature		Date
Individual Signature		Date