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