

KENTUCKY FACILITY TRANSITION PLAN

Individual's Name:

Face Sheet

Name:	DOB:	Medicaid #:	Home:	Date: Update:
Team Leader:	Case Manager:		Type of Move:	
Medicare #: RX Plan:				

Data Tracking				
Transition Support Team Members:				
IDT Recommendation Date:	Individual/Guardian Choice Date:	Provider Choice Name/Date:		Planning Meeting Dates:
Day Visit Date(s):	Overnight Visit Date(s):	Staff Cross Training Dates:		Discharge Meeting Date:
Community Case Manager Name/Phone #:		Community Home Address/Phone #:		Transition Date:

Legal Status	
Legal Status:	Source of Income:
Family/Guardian/ Address:	Field Worker (if applicable): Phone: Pager:
Phone:	

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CONTACT INFORMATION

COMMUNITY CONTACTS	FACILITY CONTACTS	Appointment Date(s):
SCL Case Manager: Phone:	Transition Facilitator Phone:606-677-4068 ext.	
Residential Provider: Contact Name: Phone:	Facility Home Manager Phone:606-677-6048 ext.	
Day Services Provider: Contact Name: Phone:	Facility Nurse Phone:606-677-4068 ext.	
Community Behavior Specialist Phone:	Facility Behavior Analyst Phone:606-677-4068 ext.	
Community Physician Address: Phone:	Facility Physician Phone:606-677-4068 ext.	
Community Psychiatrist Address: Phone:	Facility Psychiatrist Phone:606-677-4068 ext.	
Community Psychologist: Address: Phone:	Facility Psychologist Phone: 606-677-4068 ext.	
Hospital: Phone:	Area Administrator: Phone:	
Community Pharmacy Phone:	Facility Pharmacy: Phone:	
Other Medical (Type) (add as needed): Name: Phone	Other Medical (Type) (add as needed): Name: Phone	
Other Medical (Type) (add as needed): Name: Phone	Other Medical (Type) (add as needed): Name: Phone	

** For after hours support from Oakwood, please call 606-677-4068, dial 0, and ask for Administrator on Duty*

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The transition planning process has been discussed with the parent/guardian and they have been provided the opportunity to participate in this planning process. The Transition Team agrees that the attached transition plan, if carried out as described, will provide an opportunity for a successful transition to community life for the described individual.			
Transition Facilitator	Date	Community Support Coordinator	Date

DSM IV DIAGNOSIS – Axis I-V

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Health/Safety Concerns: *(Do I have any visual or hearing impairments that could create challenges? Do I have ambulatory challenges? Do I have allergies that create environmental challenges? Do I have ongoing medical needs that will effect me in my environment? Do I place small objects in my mouth or swallow them or having choking risks? Do I have a seizure diagnosis? Do I recognize that I should not follow a stranger? Do I have emotional or behavioral issues?)*

***Community Provider Crisis Plan should address the safety issues identified and be included as part of this transition plan.**

Health/Safety Concerns

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Health/Safety Concerns			
Safety Issue	Prevention	Intervention	Staff Contacts
•	•	•	Facility Contacts Community Contacts
•	•	•	Facility Contacts Community Contacts
•	•	•	Facility Contacts Community Contacts
•	•	•	Facility Contacts Community Contacts

Medication Administration:

(Can I take my medications independently? Do I take my medications whole with water? What procedure is used to hand these medications to me? Do I need to take my medications crushed and in a food product such as applesauce, pudding, or other products? What products are used for this? Do I pocket medication in my mouth instead of swallowing them? What do support staff do to help me take my medication? Do I require monitoring for medication side effects? What medications require monitoring and what side effects should staff watch for? Am I on any new medications? What possible reactions should staff watch for?)

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Socialization Patterns/Communication

(Do I use words to communicate wants and needs? Do I use sentences, word combinations, or single words? Do I use gestures? What gestures do I use to let people know what I want? Do I use sign language? Is the sign language functional language or formalized sign language? Do I use vocalizations to express needs and desires? What types of vocalizations do I use? How do I communicate pain? How do I communicate sickness? How do I indicate what I like? How do I indicate what I do not like? How do I communicate affection? Do I have problems with people being in my personal space? What is the best way for staff to communicate with me? How will staff know I understand what is being communicated?):

Housing Requirements

Meeting Date/Activities:

Meeting Date/Activities:

Meeting Date/Activities:

Meeting Date/Activities:

Meeting Date/Activities:

Meeting Date/Activities:

Family Situation, Issues, Participation

Community Supports/Training Requirements Documentation

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Community Support Services

*Place an "X" to the left if service is to be provided in the community setting.

	Service	Person Responsible:	Target Date:	Secured:	Provider:	Comments/Visits:
	Case Management					
	Residential Service Type: *Enter type of residential service to be provided (Staffed Residence, Group Home, Family Home, Adult Foster Care)					
	Day Support Services					
	Supported Employment					
	Behavior Support					
	Community Living Support (in-home support)					
	Respite					
	Occupational Therapy					
	Physical Therapy					
	Speech Therapy					
	Dietician					
	Home Health/Nursing					

Adaptive Equipment and Medical Devices

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Adaptive Equipment Needs: <small>*enter type of equipment below</small>	Person Responsible:	Target Date:	Secured:	Comments:

Individual Specific Training Required Prior to Transition

*Sign-in sheets must be maintained for documentation of all in-service training and forwarded to Transition Department for the transition file.

Training should start before the visits begin and should continue during transition process.

Individual Specific Training:	Person Responsible:	Date Provided:	Training Completed By:

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Case Manager Checklist for Preparing for the Move
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Preparing for the Move Task/Activity	Responsible Party	Completion Date(s)	Verification Signature
A combination of day and overnight visits to the community have occurred according to the plan specifications			
Name, address and phone number have been identified for: - Projected Primary Care Physician - Projected Hospital - Projected Psychiatrist - Projected Pharmacy - Projected Specialty Physicians			
First primary care visit is scheduled to occur within the first 30 days after the move			
A psychological evaluation that meets waiver criteria			
A checklist of personal belongings has been completed and provided to the transition office (<i>A copy of the inventory will accompany the individual to the community provider.</i>)			
Cross-training of all community staff has occurred			
The home has met all modifications as described in the planning process			
Transportation arrangements are made for the day of the move			

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Individual's Name:

Preparing for the Move Task/Activity	Responsible Party	Completion Date(s)	Verification Signature
The individual's belongings are packed			
The facility primary care physician has called community primary care physician to provide appropriate transfer of medical information			
The facility psychiatrist has called community psychiatrist to provide appropriate transfer of psychiatric information			
Arrangements have been made for individual spending money for community move			
An update has been made to ensure current medication list is accurate			
30 day supply of medications			
Updated doctors order including diet			
**30 day follow up visit scheduled			

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Service Availability	
The IDT agrees that services and supports are in place and transition is recommended.	
QMRP Signature:	Date:
The Transition Plan Review Committee has reviewed and approved the Transition Plan.	
Transition Director Signature:	Date:
This transition has been authorized by the Bluegrass Oakwood, Inc., Facility Director.	
Facility Director Signature:	Date:

Transition Planning Meetings/Issues/Activities
Transition Meeting Dates and Activities: List meetings/visits/consults/other transition activities by date and list any issues or barriers encountered with strategies to resolve and date of resolution.
Transition Meeting Date/Activities:

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THE DAY OF THE MOVE ACTIVITIES

Day of the Move Task / Activity	Responsible Party	Completion Date	Verification Signature
Staff from the facility accompanied the individual to the community home: <i>Departure time from facility:</i> <i>Arrival time at Community:</i>			
Transition Office has informed the business office of individual's move			
All items on personal belongings checklist have been verified through a signature by staff from facility and staff from community			
The Transition Office has forwarded the transition records to Residential Records			

***A copy of the current ILP is to be attached to this Transition Plan for training objectives to be implemented.**

***A copy of the current MAR is to be attached to this Transition Plan.**

Upon discharge:

Original: Medical Records

CC: Transition Office

Community Provider

DOJ Coordinator

