

Transition Checklist

30 Day 60 day 90 day

Name of Individual:	Site Visited:	Date:
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Preparation for the Move:

What training did you receive prior to the move and where was it provided? *(identify all areas of training)*

Facility/provided by _____
Day Service/provided by _____
Community Home/ provided by _____
Other/provided by _____

What other areas would have been helpful? _____

What issues /problems occurred on the day of the move? _____

Realization of personal goals

What positive changes have occurred in the individual's life? (behavioral, health, mood, etc.) _____

Home Life After the Move:

What issues/problems have occurred since the move? _____

How have the issues been addressed? _____

Day Services:

What does a typical day look like for the individual? _____

Is the individual enjoying his/her day service? Is this his/her chosen day service? If not how well is he/she moving toward the desired day service? _____

Family Dynamics:

What type of contact has occurred with the family? *(describe frequency and type)* _____

How has the individual responded to these contacts? _____

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ISP:

When was the individual support plan developed? _____

Describe how the plan reflects the individual's personal goals. _____

What changes or additions have been made to the ISP? _____

Participation in the life of the community.

What friends has the individual made? _____

What leisure activities does the individual enjoy in the home? _____

What kinds of leisure activities is the individual enjoying in the community? _____

Best Possible Health

Medical Support:

Has the individual had any of the medical interventions listed below?

Intervention	Date	Purpose	Outcome
Routine primary care visit			_____
Other Primary care visit			_____
Specialty physician visit (identify)			_____
Urgent care visit			_____
PT, OT, Speech visit			_____
Counseling visit			_____
Psychiatrist Visit			_____
Dental visit			_____
Hospitalization			_____
Other			_____

Describe any medication changes since the move. _____

Describe any changes in weight. _____

Describe any changes in sleeping pattern. _____

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Freedom from abuse, neglect, and exploitation

Have there been allegations of abuse, neglect, or exploitation? If so, were the allegations substantiated? If so, what actions were taken?

What training has the individual and staff had to increase knowledge of what constitutes abuse, neglect, and exploitation are and how to report?

Incident and Risk Management

Describe the number and type of incidents. _____

Does the individual Crisis Prevention Plan address all areas of concern? Has it been revised as indicated? _____

Is the individual's Behavior Support Plan current? Are the results of the Functional Analysis reflected in the plan? Has the Behavior Support Plan been revised and/or amended as indicated? _____

Consultation:

What types of consultation /training has occurred or is needed by the community provider? _____

Additional Comments:

Assessment Participants:

_____	_____
_____	_____
_____	_____
_____	_____