ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ARIZONA TRAINING PROGRAM
TRANSITION PLAN CHECKLIST

(To be completed as part of the Person Centered Plan and prior to the Service Plan)

INDIVIDUAL'S NAME (*Last, First, M.I.)*		Date
Move From:	To:	Target Date for Move:

Are Nursing Visits required during the transition? Yes No	If "Yes", explain frequency and fading criteria.
Does the member want to keep their current physical (acute) health plan? Yes No	If "No", what is their desired plan (i.e., United Healthcare or Care 1st)?
Will the member's current primary care physician continue to serve the member? Yes No	If "No" a dialogue with the member must occur regarding options of in-network primary care physicians in the member's geographical location.
Does the member need any physical health care by specialists (e.g., neurologist, cardiologist, gastroenterologist)? Yes No	If "Yes", who is the member's current specialist and what is the specialty?
Will the member's current specialist continue to serve the member? Yes No	If "No", a dialogue with the member must occur regarding options of in-network specialists in the member's geographical location.
Does the member currently receive any behavioral health services? Yes No	If "Yes", who is the member's current provider(s) and what services are being provided?
Will the member require any enhanced behavioral health services in preparation for and through the transition?	If "Yes", a dialogue with the member's behavioral health provider(s) needs to occur in order to determine the member's level of need.

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Yes No	
Will the member's current behavioral health provider(s) continue to serve the member? Yes No	If "No", a dialogue with the member must occur regarding options of in-network provider(s) in the member's geographical location.
Does the member currently attend a Day/Employment program during the day? Yes No	If "Yes", what is the current program type and vendor? Where is it located?
Will the member continue to receive Day/Employment services? Yes No	If "Yes", a dialogue with the member must occur regarding options of vendors in the member's geographic location.
Does the member currently receive any additional Long Term Care Services (e.g., Physical, Speech, Occupational Therapy, Nursing)? Yes No	If "Yes", what are the current Long Term Care Services authorized for the member? Who is the vendor for each service?
If the member is moving to a Developmental Home or Group Home, will the member continue to receive the Long Term Care Services identified above? Yes No	If "Yes", a dialogue with the member must occur regarding options of vendors in the member's geographic location.
If the member is moving home with family, will the member need Long Term Care in-home services? Yes No	If "Yes", the Support Coordinator will complete a Service Evaluation to determine the medically necessary and cost effective services the member will need.
Describe all medical equipment and personal belongings that need to be moved with the member and identify who is responsible.	
Describe the number and types of visits the member needs with the awarded vendor prior to the member's move.	

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