

**Transcriber's note.** File. E text - Appendix Q Individualized Transition Plan Checklist.pdf . Department of Economic Security. **Return to text.**

## **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, Middle initial, Date

Move From. Move To.

Target Date for Move.

Are Nursing Visits required during the transition? Yes or No

If "Yes", explain frequency and fading criteria.

Does the member want to keep their current physical, acute, health plan? Yes or No

If "No", what is their desired plan, i.e., United Healthcare or Care first?

Will the member's current primary care physician continue to serve the member? Yes or 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 or 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 or 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 or No

If "Yes", who is the member's current providers, and what services are being provided?

Will the member require any enhanced behavioral health services in preparation for and through the transition? Yes or No

If "Yes", a dialogue with the member's behavioral health providers, needs to occur in order to determine the member's level of need.

Will the member's current behavioral health providers, continue to serve the member? Yes or No

If "No", a dialogue with the member must occur regarding options of in network providers, in the member's geographical location.

Does the member currently attend a Day Employment program during the day? Yes or 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 or 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 or 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 or 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 or 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.

**End of material.**