Ligas Transition Service Plan Instructions

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A *Ligas* Transition Service Plan shall be developed specific to, and centered on, each *Ligas* Class Member (*Ligas* Consent Decree, Paragraph 10). For individuals presenting a crisis situation, refer to the Crisis Transition Plan.

The *Ligas* Transition Service Plan is a formal document. It must be typed, not hand-written.

The *Ligas* Transition Service Plan may be supplemented with a Person Centered Plan (PCP), such as a Relationship Map. Completion of the *Ligas* Transition Service Plan does not eliminate the need for a provider to complete a service plan within 30 days after an individual's entry into a waiver program. A provider has a responsibility for completing a reassessment of risk with recommendations after the individual has transitioned to the provider's services. Plans to mitigate the assessed risk will be incorporated into the service plan developed by the provider.

Ligas Transition Service Plan development should focus on the individual's personal vision, preferences, strengths and needs in home, community, and work environments. The plan shall reflect the value of supporting the individual with relationships, productive work, participation in community life, and personal decision-making. (*Ligas* Consent Decree, Paragraph 13)

The *Ligas* Transition Service Plan will be developed by a Qualified Intellectual Disabilities Professional (QIDP) employed by the Pre-Admission Screening/Independent Service Coordination (PAS/ISC) agency with geographical jurisdiction in conjunction with:

- Individual
- Individual's legal guardian, if applicable;
- Individual's family members;
- Friends;
- Support Staff [This person is familiar with the Individual and could be staff from current service (Home Based Services, ICF/DD) and would have valuable input].

A *Ligas* Transition Service Plan is required for those individuals who are leaving an ICFDD or leaving their own or family's home to receive services.

The *Ligas* Transition Service Plan meetings shall be held face-to-face between the individual and the QIDP. It is imperative that the individual be given a choice on selecting the participants involved in the *Ligas* Transition Service Plan development. The location of guardian, family members, and other members contributing to the plan may require exceptions being made for telephone participation. In order to obtain sufficient documentation, the transition planning process may require more than one meeting in order to obtain input from different contributing participants.

The *Ligas* Transition Service Plan shall:

- Describe the services the individual requires in a community-based setting or through community-based services;
- Include where and how such services can be developed and obtained;
- Include supports and services the individual will need during his or her transition to a community-based setting;
- Identify the timetable for completing the transition.

All services and supports in the *Ligas* Transition Service Plan must be integrated into the community to the maximum extent possible, consistent with the choices of the individual and where applicable, the individual's legal guardian. (*Ligas* Consent Decree, Paragraph 14)

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The *Ligas* Transition Service Plan shall not be limited by current availability of services. It should be understood that no obligation is made to providing the types of services beyond those included in the Waiver and/or the State Plan. (*Ligas* Consent Decree, Paragraph 15)

The *Ligas* Transition Service Plan should be developed through dialogue involving the Individual, Individual's legal guardian, if applicable, Individual's family members, friends, and support staff who are familiar with the individual.

The *Ligas* Transition Service Plan is not intended to duplicate information. Assessments and reports can be attached to provide further details of specific needs (e.g., psychological, ICAP, MAR). Note: Any serious needs or health risks should be clearly documented in the plan.

Within no more than twelve months prior to the development of a *Ligas* Transition Service Plan, the individual and/or guardian, in an objective manner, will be presented all of his or her service alternatives. A *Ligas* Transition Service Plan exceeding 12 months from service initiation must be updated. The *Ligas* Transition Service Plan shall be completed within sufficient time to provide appropriate and sufficient transitions of individuals in accordance with the deadlines set forth in the Decree. (*Ligas* Consent Decree, Paragraph 16)

The *Ligas* Transition Service Plan shall be initiated as individuals are selected to receive Medicaid Waiver services through the Prioritization of Urgency of Need for Services (PUNS) or a request is received reflecting a choice of Waiver services (e.g., Individuals residing in private ICFs/DD with nine or more residents).

Guidance for Service Plan Completion:

- When completing the transition plan, staff should document when an individual's preference and choice on a specific issue is of special importance to them.
- The format of the Transition Service Plan should not be used as a script. Information should be gained through conversation and dialogue.
- When referencing a person seeking services, staff should refer to the person by name or use "individual" to ensure consistency.
- Staff should be clear in their distinction between using terms such as "housemate" or "roommate". A roommate is someone sharing a bedroom. A housemate is someone residing in the same residence.
- Avoid the use of broad statements such as structured chores, shopping, and going out to eat. Specifics should be used to define individual preferences and choices.

Use of the *Ligas* Transition Service Plan:

The transition plan should be included in all referral packets sent to potential service providers. A potential provider should closely review the individual's preferences, choices, and needs. As a provider is selected, PAS/ISSA/ISC, through the ISP approval process, will ensure the Ligas Transition Service Plan (LTSP) is utilized in completing the Individual Service Plan (ISP). The LTSP should be used as a foundational tool for development of the ISP, in addition to other assessments.

Who should retain copies of the *Ligas* Transition Service Plan?

- Individual and/or Guardian
- PAS/ISSA/ISC Agency completing the LTSP
- Receiving PAS/ISSA/ISC Agency
- Residential Provider
- Day Services Provider

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Service Plan Completion:

Name:
Record individual's legal name as it would appear on a service funding packet. This area of the *Ligas* Transition Service Plan should also reflect any common names or nicknames.

Address: Current Residence

Type of Current Residence:
Describe current residence by setting and/or service type. (Note: An individual must be residing in an ICFDD of 9 or more residents, at the time they become a Ligas ICFDD class member.)

Current Daytime Activity:
What type of structured activity does the individual engage in during the day? (e.g., school, work, social settings, recreational program, or day program)

Date of Birth (DOB):
Record DOB (MM/DD/YYYY). Ensure individual is age 18 or older for established eligibility.

Guardian:
If an individual retains his/her own rights, ~~this section would be left blank~~enter "Self". The *Ligas* Transition Service Plan should state in summary that the individual retains his/her own rights. The *Ligas* Transition Service Plan document has made accommodations to reflect those having co-guardians. If no guardian has been assigned, the individual ~~may choose to~~ should be encouraged to involve someone to assist with *Ligas* Transition Service Plan development. These individuals should be listed and a consent form/release of information completed to allow contact.

PAS/ISSA/ISC:
Record the Pre-Admission Screening, Individual Service and Support Advocacy (PAS/ISSA/ISC) agency having geographical jurisdiction. The *Ligas* Transition Service Plan shall reflect the PAS/ISSA/ISC agent that completed the ~~that is responsible for~~ *Ligas* Transition Service Plan ~~completion~~ and contact information for that person. The date must reflect the completion date of the plan.

Personal Background and Social Summary
Provide a one-paragraph overview of the individual including a brief summary of the person's background, skills, abilities, current services and living situation and family. **The purpose of the Summary is to help the reader of the TSP quickly gain a picture of the individual.**

Example: Jill is a 32-year old woman who has lived at Robertson ICF/DD for the past 8 years. She attends McLean DT sheltered workshop 3 days week. Previously, Jill lived with her parents and 2 siblings in Joliet. She attended Spruance School until she aged out at 21. Jill is non-verbal and communicates with gestures and signs. She uses a motorized wheelchair for travel. Jill needs assistance and support with her ADL activities. She wants to work and earn money and would need assistance from a job coach.

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Where do you want to live?

Record the desire to live near a friend, group of friends, or others. Description should be provided to narrow choice to a geographical area of the state (e.g., Within 20 minutes or 5 miles of a desired person, close to public transportation, community resources).

Preferred Living Arrangement:

Describe setting/choice of residence. **With family, alone in own apartment, in an apartment with roommates, in 24-hour supervised group home. List preference to share bedroom and preferred number of housemates.** Identify risk factors which may include but not limited to environmental hazards, personal safety, others in the home, emergency situation response, and chemicals/cleaning products.

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Is there anyone you would like to live with?

Summarize dialogue addressing desires to maintain/establish friendships or social relationships with action steps to achieve. Is there someone you would prefer as a housemate or roommate?

Preference of Employment, Earning Money, Volunteering, Alternative Day Activity~~Day Activity~~:

Work a~~A~~ctivities the individual would like to engage in during the day (e.g., job coaching, supported and customized employment, the discovery process, self-employment., vocational opportunities, competitive employment, supported employment, developmental training. Describe past job experience and desire for future training. ~~, specific desired work experience, other).~~ Identify risk factors which may include but not limited to conflict resolution with others, use of tools and equipment, avoidance of dangers associated with tasks, and dangers posed by other persons at the worksite.

(Participation in Community Life: recreational, educational, social activities, shopping, movies, theatre, health services, fitness center, community access. Provide detail of activities currently engaged in and future desired activities. Identify risk factors)

Community Opportunities:

Focus on preferences, strengths, and needs. Identify services and supports to be integrated into the community to the maximum extent possible in order to gain a presence in the community (e.g., medical services, beautician/barber services, recreational, educational, pedestrian skills, identify risk factors.) Risk factors could include but not limited to traffic skills, vision or hearing supports, access to community/neighborhood, understanding of stranger, conflict resolution with others, and ability to use a cell phone or communicate from a community setting.

Personal Preferences:

This section is intended to identify personal likes and dislikes of the individual. The current and future vision/hopes should be identified and addressed in detail to summarize desire and choice. Discussion shall focus on likes and dislikes in a variety of settings and aspects (e.g., home, community, social, recreational, spiritual, and educational opportunities).

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Family Involvement/Relationships:

This area should summarize relationships which support personal success. ~~It should further identify those relationships which may pose an obstacle in recording achievement and gaining independence.~~ **(Describe family members including siblings, aunts, uncles and extended family relationships, supportive members, , Interpersonal relationships outside the family. Provide family history including siblings and extended family relationships, former staff, teachers, supportive individuals). Detail any Guardian's restrictions due to safety issues, Legal Restraining Order.** It should further identify those relationships which may pose an obstacle in recording achievement and gaining independence.

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Communication Skills:

How does the individual choose to communicate? Include present, past and/or needed use of Assisted Technology, Augmentative Alternative Communication Devices. Identify communication assessments and therapies presently provided or in the past (e.g., preferences and choices on how the person communicates and with whom; Identify risk factors). ~~-~~Risk factors could include but not limited to the ability to express the need for medical attention or emotional supports.

For further detail, communication assessments and reports, if available, should~~may~~ be referenced and attached.

Mobility:

Choices and desires associated with mobility issues (e.g., accessibility, space, transferring, level of assistance. Adaptive equipment used for mobility should be specified here and in the Adaptive Equipment section. ~~,~~ Identify risk factors). Risk factors could include but not limited to falls/fractures, use of stairs/escalator/elevator, accessing a motor vehicle, fire evacuation, and issues related to physical status –obesity, shortness of breath, weakness, and skin breakdown.

For further detail, mobility assessments, fall prevention plans and reports, if available, should be referenced and /or ~~may be~~ attached.

Personal Care:

Summarize tasks which may be attempted and/or completed. Level of support needed to complete certain tasks. Identify risk factors. Risk factors could include but not limited to adjusting water temperatures, access to cleaning/hygiene supplies, noncompliance to tasks, and lifestyle choices that negatively affect health.

For further detail, assessments and reports may be attached.

Meal Time Assistance:

Summarize the level of supports needed at meal times. Is staff needed to assist with monitoring food intake during meals? Personal preferences and identified risk factors should be documented. Consideration should be given for "Use of the Kitchen" (stove, refrigerator, silverware, cooking implements, dishes, food items, adjusting hot & cold water, dishwasher, microwave, coffee maker, toaster, and other appliances). Risk factors could include but not limited to choking and/or aspiration, swallowing disorders, postural support, potential for injury, and behavioral support.

For further detail, clinical assessments and reports, if available, should be referenced and/or attached.

Special Dietary Needs:

Summarize restrictions and/or programming which will ensure dietary needs. Risk factors could include but not limited to significant weight loss or gain, allergies, and likes/dislikes in food preferences.

For further detail, dietary assessments and reports, if available, should~~may~~ be referenced and/or attached.

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Personal Decision making:

Summarize decisions the individual does make and situations when personal decision-making can be maximized (e.g., Money skills, banking, ability to make purchases, scheduling, community access, giving direction, following direction, time management, attention to task, participation, religion, and leisure activities). Risk factors could include but not limited to money management skills, risk of financial exploitation, social/friendship choices, telephone usage, comprehension and processing skills, and television/movie viewing.

Adaptive Equipment / Protective Equipment:

Summarize equipment or resources which increase independence or maintain safety (e.g., hearing aids, glasses, helmet, lift, plate guard, AFO, language device, specialized chair). The use of adaptive/protective equipment should be supported in the Medical/Physical Well-Being domain. Risk factors associated with adaptive/protective equipment should be listed. Risk factors could include but not limited to potential choking or strangulation hazards, two-person assist, sensory loss, skin breakdown, heat caution, fall precaution, and re-positioning.
For further detail, assessments and reports may be attached.

Behavior Supports:

Summarize behavior and needed supports. Identify behavior modification techniques which may be effective. Include summary of behavior, frequency, severity, antecedents, duration, successful interventions and last episode). Risk factors could include but not limited to identifying techniques which are not effective, potential risk to self or others, isolation, refusal of services, elopement, substance abuse, inappropriate sexual behaviors, and law enforcement involvement.
For further detail, a Behavioral Plan, if available, should be referenced and/or ~~assessments and reports may be~~ attached.

Medical / Physical Well – Being:

Summarize medical history, chronic medical conditions, consequences, and services for support. Include need for Physical and Occupational Therapies. Risk factors could include but not limited to sensory impairments, frequent falls, compliance towards recommendations, significant number of medical visits, inability to tolerate a medical examination/procedure, perceived linkage of medical professionals.
For further detail, assessments and reports, if available, should ~~may~~ be attached.

Medications:

Describe ability to self-medicate. What level of assistance is currently being provided to take medication(s)? Risk factors could include but not limited to medication side effects, allergies to medications, ineffective/harmful medical interventions. It is extremely helpful to providers to include a summary list of medications. ~~For further detail, assessments and reports may be attached~~.

Legal Issues:

Summarize court/police involvement, trust fund Issues, guardianship, consents.

Other Risk Issues Not Identified or Human Rights Restrictions~~:~~

Summarize events or actions which may lead to certain consequences. Detail human rights restrictions such as limitations on visiting, food, room locks, behavioral interventions, etc.
For further detail, assessments and reports should~~may~~ be referenced and/or attached.

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Summary:

Summary of Past Transition and/or Supports:
Summarize individual history as it relates to past transitions (e.g., residential and service supports). This section may also contain a documented social history.

Support Needs and Time Table for Transition:
Summarize supports/activities needed to transition (e.g., overnight visit, day visit, dinner visit, staff familiarization, adjustment period). Develop a chronological schedule and process to summarize the transition.

Transition to new PAS/ISSA/ISC Agency:
This section should be completed by the Current PAS/ISSA/ISC Agency when the individual is moving to a new geographical location, transfers to another service, or the Individual chooses to receive services from a new PAS/ISSA/ISC Agency. A summary should be provided which indicates the date planned for the new PAS/ISSA/ISC to assume responsibilities. The current PAS/ISSA/ISC is responsible for documenting the dates in which the new PAS/ISSA/ISC Agency was notified of this assumed responsibility.

People who attended ~~contributed to~~ the *Ligas* Transition Service Plan meeting:
Ensure all people who attended ~~participants in~~ the *Ligas* Transition Service Plan meeting have been identified by name and title/relationship. Multiple meetings may be held to complete the *Ligas* Transition Service Plan process. Ligas Compliance Standards require the participation of the individual and/or guardian in the Ligas Transition Service Plan. Family, friends, current staff, and those deemed important in the individuals life should be encouraged to participate. ~~considered as potential participants.~~