Ligas Transition Service Plan

Track It Changes Document (DRAFT COPY)

See Instructions for completion of the Transition Service Plan

Name of Individual: _____

Address: _____

City: _____ **Zip:** _____ **County:** _____

Type of Current Residence: _____
(Family Home, ICF/DD)

Current Daytime Activity: _____ **How many hours/days/week?**_____

Home Supports (# of hours, if receiving): _____

Date of Birth: ___/___/____

Name of Guardian: _____ – **If no Guardian, mark "Self"**
Relationship to individual: (family, friend, OSG, other: describe: _____
Type of Guardianship: _____

City / County of Guardian's Residence: _____

Telephone Number: (___)_____ **E-mail Address:** _____

(SEE BELOW FOR CO-GUARDIANSHIP)

Name of Guardian: _____ **Type of Guardianship:** _____

City / County of Guardian's Residence: _____

Telephone Number: (___)_____ **E-mail Address:** _____

IF NO GUARDIAN, FAMILY CONTACTS: (release(s) on file for family members, friends, etc)

Name: _____**Relationship:** _____

Telephone Number: (___)_____ **E-mail Address:** _____

Family Member City/ County Residence: _____

Current PAS/ISSA/ISC AGENCY: _____ _____

Transition Plan Completed by (Name of PAS/ISSA/ISC AGENT): _____ **Date:** _____

Address: _____

Office Phone: (___)_____ **Cell Phone(___)**_____ **Fax Number: (___)**_____

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INDIVIDUAL'S NAME: _____

Email Address: _____

Personal Background and Social Summary) 1-paragraph

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.**

(See Example in TSP Instructions)

Note: Information must be typed, not hand-written.

Where do you want to live?
(City, county, or geographic region; near friends, relatives, easy access to public transportation, near employment, day time activity, recreational services)

Preferred living arrangement?
(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)

Is there anyone you would like to live with?
(Friendships, potential housemates)

Preference of Employment, Earning Money, Volunteering, Alternative Day Activity:
(Job coaching, supported and customized employment, the discovery process, self-employment. Describe past job experience and desire for future ~~Desired~~ training, day activities, vocational opportunities, identify risk factors)

Community Opportunities
(Participation in Community Life: 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, social activities, shopping, movies, theatre, health services, fitness center, community access, pedestrian skills. Identify risk factors.) ~~**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)~~**

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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).

~~**(Likes, Dislikes, Interests, Hobbies, Current and Future Vision/Hopes, Religion, Cultural Customs)**~~

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Family Involvement / Relationships:

(Describe family members including siblings, aunts, uncles and extended family relationships, s~~S~~upportive m~~M~~embers, ~~Guardian's restrictions due to safety issues, Legal Restraining Order~~, 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

Communication Skills:

(Method of Communication, ~~Equipment,~~ Style of Understanding, (e.g., preferences and choices on how the person communicates and with whom) Include present, past and/or needed use of Assistive Technology, Augmentative Alternative Communication Devices (AAC). Identify communication assessments and/or therapies provided currently or in the past. 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 be referenced and/or attached.
~~**identify risk factors)**~~

Mobility:

(Assistance needed in transferring, Adaptive equipment used and/or needed~~s~~, Accessible living arrangement, 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 attached.

Personal Care:

(Meal Preparation, Eating, Hygiene, Bathing, Dressing, Household Chores, Repositioning, Level of Support, identify risk factors)

Meal Time Assistance:

(Summarize the level of supports needed at meal times. Include adaptive equipment, if any. **Identify risk factors)** 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.

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Special Dietary Needs:

Summarize restrictions and/or programming, which will ensure dietary needs. (Identify Risk Factors) 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 be referenced and/or attached.
~~**(Identify risk factors)**~~

Personal Decision Making:

(Ability to make decisions, Level of support needed in making decisions, identify risk factors.)
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, meal preparation, 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 provided and/or needed equipment or resources, which increase independence or maintain safety (e.g. ~~**Use of**~~ **hearing aids, glasses, wheelchairs, walkers, safety helmet, plate guard, Hoyer lift, etc.) Communication devices should detailed in the Communication domain. 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.)**

Behavior Support Needs:

(Supports needed for specific behaviors)~~**, identify risk factors)**~~Include summary of behavior, frequency, severity, antecedents, duration, successful interventions and last episode). **Identify risk factors**.

For further detail, a Behavioral Plan, if available, should be referenced and/or attached.

Medical / Physical Well-Being

(Healthcare supports needed, identify risk factors)
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 be referenced and/or attached.

Medications:

(Does the individual take his/her own medication without assistance? What assistance is the individual currently receiving? Identify risk factors)
It is extremely helpful to providers to include a summary list of medications.

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INDIVIDUAL'S NAME: _____

Legal Issues:
(Court/police involvement, Conservatorship, Trust Fund Issue)

"Other Risk" Not Identified Above or Human Rights Restrictions:
(Community Access, Assessments) Detail human rights restrictions such as limitations on visiting, food, room locks, behavioral interventions, etc.

Summary of Past Transition and/or Supports
(Current/Past Services & Supports, Social Summary, Residential History)

Support Needs and Time Table for Transition
(Day Visit, Overnight, Dinner Visit, Adjustment Period, Familiarization with staff, and a Schedule summarizing the Transition Process will be developed.)

Transition to new PAS/ISSA/ISC Agency, if applicable.
(Document New PAS/ISSA/ISC Agency, Purpose of Transfer, Date of Informing New PAS/ISSA/ISC Agency, Planned Date of Transfer)

Date(s) of TSP Team Meeting: _____

Did the Class Member attend and participate in the TSP meeting? Yes/No: If not, please justify:

_____

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INDIVIDUAL'S NAME: _____

Describe Class Members participation in th plan: _____

_____

People who attended the~~contributed to the~~ Transition Service Plan meeting:
(The plan should document efforts to resolve any barriers limiting participation.)

Printed Name	Signature	Title
		Individual
		Guardian (If Applicable)
		PAS/ISSA (QIDP)

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Approval of Transition Service Plan

Printed Name	Signature and Date	Title
		Individual (signature or mark)
		Guardian(s) (If Applicable)
		Other (detail)

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If the Class Member is unable to sign, so indicate.