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| cid:image002.jpg@01DA9C9B.873348C0 | **Pre-Placement Meeting (PPM) Transition Form** |

**Purpose**

The Plan Coordinator, with input from the individual, caregivers, Residential Provider, and other members of the planning team, completes the Pre-Placement Meeting Transition Form in advance of an individual’s planned move into a provider-managed residential setting (licensed or unlicensed). This helps ensure all elements of care and logistics related to the move have been considered. Completion of this form may prompt changes to the Individualized Service Plan to ensure all documentation is aligned and up to date.

**Instructions**

* Once completed, the Plan Coordinator distributes the form to team members and uploads it in iRecord.
* If unable to answer a question, enter a description of the status or next steps.
* If a question does not apply, enter N/A.
* **Important**: Include all action steps in the **Follow-up Action Steps** section at the end of the form.

**Notes**

* Beginning 30 days after placement, the provider communicates updates to the service plan via the *ISP Revision and Notification Form*.

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| **Identifying Information** | | | | | |
| Individual’s Name: Enter text.  DDD ID#: Enter text.  Date of PPM: Enter a date. | | | NJCAT Score: Self-Care, Behavioral, Medical  Tier: Choose an item.  Acuity: Behavioral Medical Both N/A | | |
| Current Address: Enter text. | | | Residence Type: Choose an item. | | |
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| Proposed Address: Enter text. | | | Proposed Residence Type: Choose an item. | | |
| Provider’s Name: Enter text. | | |
| Support Coordination Agency or Division Unit: Enter text. | | | | | |
| Plan Coordinator’s Name: Enter text. | | | | | |
| Phone #: Enter text. | | | Email Address: Enter text. | | |
| **Contacts** | | | | | |
| *Ensure HIPAA forms are completed, iRecord is up to date, and guardianship documentation is uploaded.* | | | | | |
| Guardianship Status: Choose an item.  Guardian Name: Enter text.  Relationship: Enter text.  Address: Enter text.  Phone Number: Enter text.  Email Address: Enter text. | | | Name of Primary Family Contact:  Enter text.  Relationship: Enter text.  Address: Enter text.  Phone Number: Enter text.  Email Address: Enter text. | | |
| Other family members or close friends important to the individual. List name(s), relationship, and best way to contact: Enter text. | | | | | |
| Professional contacts (Department of Children and Families, Adult Protective Services, Probation Office, Religious/Civic affiliations, etc.) List name(s), relationship, and best way to contact:  Enter text. | | | | | |
| Discussion notes. Include descriptions of important relationships, both personal and professional. Describe each one’s involvement or role and how often visits are preferred/required: | | | | | |
| Enter text. | | | | | |
| **Provider Information and Expectations** | | | | | |
| Has the individual/legal guardian/family reviewed the provider’s residential agreement, individual contribution, and policies? | | | | | Yes No |
| Does the provider have a policy regarding personal inventory? | | | | | Yes No |
| If yes, was it discussed? | | | | | Yes No |
| Were expectations discussed regarding frequency of contact with the legal guardian / family members? | | | | | Yes No |
| Were visitation plans discussed? | | | | | Yes No |
| Discussion notes: Enter text. | | | | | |
| **Insurance Information** | | | | | |
| According to iRecord, is Medicaid eligibility current and expected to continue? | | | | | Yes No |
| Current program enrollment: Choose an item. | | | | | |
| If not on the CCP at this time, is CCP eligibility approved? | | | | | Yes No |
| Does the individual have Medicare? Yes No | | | Medicare #: Enter text. | | |
| Private insurance? Yes No  ID #: Enter text. | | | Carrier: Enter text.  Group #: Enter text. | | |
| Discussion notes *(if CCP eligibility is in process, please explain)*: Enter text. | | | | | |
| **Documentation** | | | | | |
| Use the checkboxes to indicate which documents the provider requires and whether a copy will be accepted. | | | | | |
|  | Required? | Copy accepted? | | Add comments as needed to describe the status. | |
| Birth Certificate | Yes No | Yes No | | Enter text. | |
| Social Security Card | Yes No | Yes No | | Enter text. | |
| NJ State ID | Yes No | Yes No | | Enter text. | |
| Other ID | Yes No | Yes No | | Enter text. | |
| Health insurance card(s) | Yes No | Yes No | | Enter text. | |
| DDD eligibility letter | Yes No | Yes No | | Enter text. | |
| Guardianship judgment | Yes No | Yes No | | Enter text. | |
| Social history | Yes No | Yes No | | Enter text. | |
| All referral information | Yes No | Yes No | | Enter text. | |

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| **Medical Providers** | | | | | | | | |
| List all **current** treatment providers and indicate whether the provider will change after the move occurs. (Include all medical, psychological, and therapeutic specialists.) | | | | | | | | |
| **Primary Care Physician** | | | | | | | | |
| Name: Enter text.  Phone #: Enter text.  Address: Enter text. | | | | | Date of last appointment: Enter text.  Date of next appointment: Enter text.  After the move, this provider will:  Stay the same Change | | | |
| **Dental** | | | | | | | | |
| Name: Enter text.  Phone #: Enter text.  Address: Enter text. | | | | | Date of last appointment: Enter text.  Date of next appointment: Enter text.  After the move, this provider will:  Stay the same Change | | | |
| **Specialty: Enter text.** *(To add Specialty Providers, click below and click the blue plus sign,* **+***, on the right.)* | | | | | | | | |
| Name: Enter text.  Phone #: Enter text.  Address: Enter text. | | | | | Date of last appointment: Enter text.  Date of next appointment: Enter text.  After the move, this provider will:  Stay the same Change | | | |
| **Provider Changes** | | | | | | | | |
| List all **new** treatment providers that will take over the individual’s care after the move occurs. | | | | | | | | |
| **Provider Type: Enter text.** *(To add Providers, click below and click the blue plus sign,* **+***, on the right.)* | | | | | | | | |
| Name: Enter text.  Phone #: Enter text.  Address: Enter text. | | | | | An appointment should occur by this date:  Enter text.  Who will schedule the appointment and when?  Enter text. | | | |
| Discussion notes: Enter text. | | | | | | | | |
| **Financial** | | | | | | | | |
| SSA benefits? | Yes No | | Amount: Enter text. | | | | | |
| SSI benefits? | Yes No | | Amount: Enter text. | | | | | |
| Other benefits? | Yes No | | Explain: Enter text. | | | | | |
| How much money can the individual hold without assistance? Enter text. | | | | | | | |  |
| **Representative Payee** | | | | | | | | |
| Representative Payee’s Name: Enter text. | | | | | Relationship: Enter text. | | | |
| Phone #: Enter text. | | | | | Email Address: Enter text. | | | |
| Will the representative payee be changing? | | | | | | | | Yes No |
| If yes, who is proposed? Enter text. | | | | | Relationship: Enter text. | | | |
| Phone #: Enter text. | | | | | Email Address: Enter text. | | | |
| Has a copy of [Guidance on Division Funding and Individual Funds Charged/Collected by Residential Providers](https://www.nj.gov/humanservices/ddd/documents/guidance-on-ddd-funding-and-residential-provider-charges.pdf) been provided to the individual/family/representative payee? | | | | | | | | Yes No |
| Has the Individual Contribution been discussed and agreed to? | | | | | | | | Yes No |
| Individual Contribution amount: Enter text. | | | | | | | | |
| Discussion notes *(include a description of whether assistance is needed with finances)*:  Enter text. | | | | | | | | |
| **Day Activities** | | | | | | | | |
| What does the individual currently do during the week? Choose an item. | | | | | | | | |
| Briefly describe (include name of provider/place of employment, hours, activities, etc.):  Enter text. | | | | | | | | |
| After the move, this arrangement will: Stay the same Change | | | | | | | | |
| If day activities will be changing, has the new arrangement been set up already? | | | | | | | | Yes No |
| If yes, describe the new arrangement (include name of provider/place of employment, hours, etc.). | | | | | | | | |
| If no, describe the status of arranging new day activities. | | | | | | | | |
| Enter text. | | | | | | | | |
| How will transportation occur to/from day program or work?  Enter text. | | | | | | | | |
| Discussion notes *(include a description of barriers, if any, and how they are being addressed)*:  Enter text. | | | | | | | | |
| **Self-Care / Supervision Needs** | | | | | | | | |
| Is the ISP up to date, complete, and accurate with regard to the following?  *(All “No” responses require the ISP to be updated and redistributed.)* | | | | | | | | |
| Level of independence / support needs regarding self-care: | | | | | | | Yes No | |
| How the individual would evacuate in an emergency: | | | | | | | Yes No | |
| Current alone time at home: | | | | | | | Yes No | |
| Current alone time in the community: | | | | | | | Yes No | |
| Traveling in the community: | | | | | | | Yes No | |
| Has an Unsupervised Time Assessment been completed? | | | | | | | Yes No | |
| If yes, does the provider have a copy? | | | | | | | Yes No | |
| Upon admission, will alone time at home/in the community change? | | | | | | | Yes No | |
| Does the individual require personal guidance? *(See CCP policy manual, section 18.1.)* | | | | | | | Yes No | |
| Is the individual able to provide informed consent to engage in sexual activity/intimacy? | | | | | | | Yes No | |
| Discussion notes *(include any special instructions/information the individual/family wishes to convey)*:  Enter text. | | | | | | | | |
| **Behavioral Support Needs** | | | | | | | | |
| Is the ISP up to date, complete, and accurate with regard to behavioral support needs? *(If “No,” the ISP must be updated and redistributed.)* | | | | | | Yes No | | |
| Is there a history of elopement or walkaway incidents? | | | | | | Yes No | | |
| Is there a history of aggression towards self, others, or property? | | | | | | Yes No | | |
| Is a behavior support plan in place? | | | | | | Yes No | | |
| If yes, does the provider have a copy? | | | | | | Yes No | | |
| Do any of the following apply currently or in the past: legal involvement, fire setting, or sexually inappropriate behaviors? If yes, discuss and document below. | | | | | | Yes No | | |
| If yes, has a risk assessment been completed? | | | | | | Yes No | | |
| Does the Planning Team recommend a risk assessment or referral to CARES, the DDD Resource Team, or another entity for behavioral support? | | | | | | Yes No | | |
| Discussion notes *(include any special instructions/information the individual/family wishes to convey)*:  Enter text. | | | | | | | | |
| **Medical Support Needs / Health Status** | | | | | | | | |
| Is the ISP up to date, complete, and accurate with regard to the following?  *(All “No” responses require the ISP to be updated and redistributed.)* | | | | | | | | |
| Diagnoses: | | Yes No | | | Dietary information: | Yes No | | |
| Health hazards: | | Yes No | | | Food/liquid consistency: | Yes No | | |
| Allergies: | | Yes No | | | Mealtime supervision: | Yes No | | |
| Ambulation/risk of falling | | Yes No | | | Risk of choking: | Yes No | | |
| Adaptive equipment: | | Yes No | | | Medication: | Yes No | | |
| Does the individual self-medicate? | | | | | | Yes No | | |
| If yes, does the provider have a copy of the Self-Medication Assessment? | | | | | | Yes No | | |
| Does the provider have a policy regarding self-medication? | | | | | | Yes No | | |
| Discussion notes *(include any special instructions/information the individual/family wishes to convey)*:  Enter text. | | | | | | | | |
| **Medical Documentation** | | | | | | | | |
| Will the following documents be available for the provider by the time of the move? (*Add comments as needed to describe the status.)* | | | | | | | | |
| All medication prescriptions | | | | Yes No Enter text. | | | | |
| All medical equipment prescriptions | | | | Yes No Enter text. | | | | |
| Over the Counter Medication form | | | | Yes No Enter text. | | | | |
| Current annual medical | | | | Yes No Enter text. | | | | |
| Current annual dental | | | | Yes No Enter text. | | | | |
| Current lab work | | | | Yes No Enter text. | | | | |
| Immunization history | | | | Yes No Enter text. | | | | |
| Free from Communicable Diseases form | | | | Yes No Enter text. | | | | |
| * *To be completed within 72 hours prior to move* | | | | | | | | |
| Discussion notes: Enter text. | | | | | | | | |
| **Specialized Staff Training** | | | | | | | | |
| If the individual has an acuity, has the Addressing Enhanced Needs Form (AENF) been completed with the provider? | | | | | | N/A Yes No | | |
| Describe the status if applicable: Enter text. | | | | | | | | |
| Is specialized staff training needed for any of the following?  Self-Care Behavioral Needs Medical Needs N/A | | | | | | | | |
| Describe each area for which specialized training is needed: Enter text. | | | | | | | | |
| Describe the plan for provider staff to receive specialized training: Enter text. | | | | | | | | |
| **ISP Outcomes and Services Review** | | | | | | | | |
| Are changes/additions needed to outcomes? | | | | | | | | Yes No |
| If yes, please describe *(be specific)*: Enter text. | | | | | | | | |
| Are changes/additions needed to services? | | | | | | | | Yes No |
| If yes, please describe *(be as specific as possible about the service, number of units, and dates)*:  Enter text. | | | | | | | | |
| Discussion notes: Enter text. | | | | | | | | |
| **Transition Plan** | | | | | | | | |
| The Planning Team should discuss transition visits, including transportation.  Describe the transition plan in terms of day visits and/or overnight visits, how many and when? | | | | | | | | |
| Enter text. | | | | | | | | |
| List the target dates for transition visits:  Enter text. | | | | | | | | |

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| **The Target Move Date is:** Enter text. |

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| **Day of the Move** | | |
| Who will bring the individual to the home on the day of the move?  Enter text. | | |
| Special instructions regarding the move (time of arrival, who should/should not be present, etc.):  Enter text. | | |
| Furniture items provided by the residential provider:  Enter text. | | |
| Furniture items provided by the individual/family:  Enter text. | | |
| How are the individual’s belongings getting to the home?  Enter text. | | |
| Special instructions regarding belongings:  Enter text. | | |
| Additional discussion notes:  Enter text. | | |
| **Follow-up Action Steps** | | |
| For each category, identify the follow-up action steps and person responsible. | | |
| **Category** | **Person Responsible** | **Action Needed** |
| **Contacts** | Enter text. | Enter text. |
| **Insurance Information** | Enter text. | Enter text. |
| **Documentation** | Enter text. | Enter text. |
| **Medical Providers** | Enter text. | Enter text. |
| **Financial** | Enter text. | Enter text. |
| **Day Activities** | Enter text. | Enter text. |
| **Self-Care /**  **Supervision Needs** | Enter text. | Enter text. |
| **Behavioral Support Needs** | Enter text. | Enter text. |
| **Medical Support Needs / Health Status** | Enter text. | Enter text. |
| **Specialized Staff Training** | Enter text. | Enter text. |
| **ISP Outcomes and Services** | Enter text. | Enter text. |
| **Transition Plan** | Enter text. | Enter text. |
| **Day of the Move** | Enter text. | Enter text. |
| **General** (if not already included above) | Enter text. | Enter text. |

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| **Pre-Placement Meeting Participants** *(To add rows click in the last row, click the blue plus sign,* **+***, on the right)* | | |
| **Name** | **Title/Relationship** | **Agency** |
| Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. |

Planning Team members absent from the Pre-Placement meeting:

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| **Name** | **Title/Relationship** | **Agency** |
| Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. |
| Enter text. | Enter text. | Enter text. |