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| **Attachment 1** |

**Client Name:**  **Meeting Date:**

**Serial #:** **Projected Placement Date:**

**Services Goals/Objectives Prior To Placement Frequency/Comment Person(s)**

 **Responsible**

|  |  |  |  |
| --- | --- | --- | --- |
| **Support Coordination (SC) / Case Management (CM)** | **Current SC /CM:** **Current SC/CM Supervisor:** **Receiving SC/CM:** **Receiving SC/CM Supervisor:** **Annual Plan Date:**  |       | **Sending SC/CM is responsible for securing information.** |
| **Living Arrangement** | **Current Living Arrangement:****New Living Arrangement- Name:****Address:****Telephone # :****Ambulation Concerns?** **In-service training needed?****Identify the number of transition visits needed:****Shadow visits: \_\_\_\_\_\_****Day visits: \_\_\_\_\_\_\_****Overnight visits: \_\_\_\_\_\_****Identify issues related to placement:** | Discuss the need for a fire drill to be completed during the first overnight visit to the new home.  | **Sending SC/CM is responsible for securing information.** |
| **Identification Documentation** | **Birth Certificate: Yes** ☐ **No** ☐**Social Security Card: Yes** ☐ **No** ☐**State ID: Yes** ☐ **No** ☐**Other ID:** **Health Insurance Cards: Yes** ☐ **No** ☐ | Discuss whether original documents are needed or if copies will be accepted. | **Sending SC/CM/Natural Support is responsible for securing information.** |
| **Employment/ Education/ Habilitation** | **Current Job/Day Program:** **Name/site of new Job/Day Program:** **Referrals sent, if site is not identified above:** **Transportation arrangements:** **Contact Person:** **Telephone #:** **Date of visit to site:**  | Work / Day Program hours of operation:       | **Sending SC/CM is responsible for securing supports and services.** |
| **Family/** **Community Contacts** | **Family Contacts:** **Address:****Telephone Number:****Religious/Civic Affiliations:** **DCF/APS Contacts:** | Frequency of contact identified by client: | **Sending SC/CM is responsible for securing information.** |
| **Fiscal** | **CCW Eligible: Yes****[ ]  No****[ ]** **Supports Program Eligible: Yes[ ]  No[ ]** **SSA Benefits: Yes****[ ]  No****[ ]** **SSI Benefits: Yes****[ ]  No****[ ]** **Other Benefits:** **Payee Name:** **Address:** **Telephone:** **Willingness to transfer payeeship to agency:** **Yes[ ]  No[ ]  Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(Attach completed Choice, SCAT, & CERT)****Contribution to Care amount:** Click here to enter text. | Discuss Contribution to Care with individual and family:Cash on Hand should be brought on the day of move. Discuss amount:Amount of money individual can hold on their person at any time:      | **Sending SC/CM is responsible for securing information.** |
| **Guardianship** | **Guardianship status: eg.** (private, self, BGS)     **Date Established:** **Name:** **Address:** **Telephone #:** **Relationship:**  | **How involved is the guardian?**\*Agency needs a copy of official guardianship paperwork. | **Sending SC/CM/Natural Support is responsible for securing information.** |
| **Health** | **Medical Insurance: Yes** **[ ]  No** **[ ]** **Carrier:**  **ID#:** **Group #:** **Private Insurance Carrier:** **Phone #:** **Chosen Community HMO:****Annual Medical- Date:** **Annual Dental- Date:** **72 hr. free from Contagious- Date:** **Primary care physician:** **Dentist:****Specialty Physician:** **Mental Health Professionals:** **Prescriptions for:*** **Special needs/Equipment (DME):**
* **Medications:**

**Lab Work:****Special diet:** **Allergies:****Diagnosis:****Significant Medical issues- explain:** **Will any physicians change? If so, provide name and contact info.****\*Attach list of Medications; include dosage, times of administration and treatment purpose.** | Medicare:Medicaid HMO:How is medication administered (whole with water, crushed in pudding, etc):How does individual handle doctor visits and blood work (any special instructions):\*Discuss Over the Counter form (provide a copy to individual or family if they do not have one already)The receiving provider agency will coordinate the receipt of prescriptions for medication and durable medical equipment (DME) along with Letters of Medical Necessity.  | **Receiving Provider Agency is responsible for securing supports and services.** |
| **Personal Care** | **Level of support needed for ADL’s:****Unsupervised Time in home: Yes** **[ ]  No** **[ ]** **Unsupervised Time in community: Yes** **[ ]  No** **[ ]** **(Attach completed Unsupervised Time assessment-** **Self Medicating?: Yes** **[ ]  No** **[ ]  (Attach completed Assessment for clients currently self medicating)** | Describe the level of assistance the individual needs with each Activity of Daily Living (ADL):\*This individual requires 24 hour on-site supervision until Unsupervised Time Assessment is completed by agency. | **Sending SC/CM is responsible for securing information.** |

**Team Members Title Agency**

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**Comments:**

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**Review/Approval**

**SC/CM Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**