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| **Participant:** | **Change in:** |  |
|  | Case Manager  Location [physical relocation within Wyoming]  Provider  Residential move within provider organization |  |

**Notes:**

* The case manager must complete the Transition Checklist in its entirety and upload it into the Electronic Medicaid Waiver System (EMWS) using the EMWS File Naming Convention Guidelines.
* For the purpose of this form, *Provider* refers to case managers and any provider of DD Waiver services unless otherwise specified.
* If there are circumstances that are not addressed by this checklist, please contact your Benefits and Eligibility Specialist (BES).

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|  | **Task** | **Date contacted, received, or completed** |
| 1. | Provider gave 30 day notice **OR**  Participant or legally authorized representative notified Division or case manager of their desire to change their case manager, location, or provider. |  |
| 2. | Case manager contacted the BES within three (3) business days of receiving notice. |  |
| 3. | Case manager reviewed the transition process with the participant or legally authorized representative, provided choice in providers, and presented the appropriate forms.   * A Case Management Selection Form was received. | Yes  N/A |
| 4. | Case manager confirmed that the newly selected provider meets the qualifications to deliver the service, including certification in the specific service and service tier.   * Provider agreed to the available units for the service * Affected roommates have been informed of and agree to the new roommate. | Yes  No  Yes  N/A |
| 5. | Case manager coordinated the transition meeting, and notified the Division and plan of care team at least two weeks prior to the transition meeting. | Notification Date:    Meeting Date: |
| 6. | Case Manager shared copies of the following information with the new provider: |  |
| 1. Plan of care |  |
| 1. Positive Behavior Support Plan, behavioral data, protocols, guidelines | 1. N/A |
| 1. Task analyses and progress reports on status of training goals | 1. N/A |
| 1. Schedules |  |
| 1. Guardianship documents | 1. N/A |
| 1. Equipment inventory (how and when equipment is used, and any training that will be necessary) | 1. N/A |
| 1. Evaluations and assessments not assigned to other team members | 1. N/A |
| 1. Level of Care score | 1. N/A |
| 1. Remaining individual budget amount (IBA) |  |
| 1. Projected units to be used through the transition date |  |
| 1. Nursing assessments within the last 12 months    * Health review checklists covering the last 12 months    * Current medication list and 12 months of historical information    * Medications (amount sent to new provider for refills)    * Skilled nursing orders (if applicable)    * Physical examination and information regarding doctor(s) appointments over the last 12 months. |  |
| 1. Assessments and treatment plans for all therapy services | 1. N/A |
| 1. Seizure protocol and summary of seizure reports | 1. N/A |
| 1. Mealtime guidelines | 1. N/A |
| 1. Positioning guidelines | 1. N/A |
| 1. Current psychological/neuropsychological evaluation |  |
| 1. Current ICAP assessment | 1. N/A |
| 1. Other assessments or evaluations that have occurred in the last 12 months | 1. N/A |
| 7. | Case manager sent a summary of the following information to the new provider   * Health and safety issues * Progress on objectives * Incidents that have occurred within the last 12 months * Other pending issues |  |
| 8. | During the transition meeting, the plan of care team reviewed and modified the following, as applicable: |  |
| * 1. Participant needs that must be met to ensure a smooth transition (i.e., history of participant difficulty with transitions, etc.) |  |
| * 1. Transportation – who is doing what and when? | 1. N/A |
| 1. Transfer of finances | 1. N/A |
| 1. Transfer of medications | 1. N/A |
| 1. Changes in cost of living (i.e., room and board changes, utility expenses and installation charges) | 1. N/A |
| 1. Moving facilitation and expenses (i.e., who will be responsible, date and time, moving costs) | 1. N/A |
| 1. Participant belongings (i.e., who is responsible, who will conduct the possession inventory and when) | 1. N/A |
| 1. Availability of current activities (i.e., bike riding, church, riding the bus) and how to address changes | 1. N/A |
| 1. Current extraordinary care requests and upcoming reviews | 1. N/A |
| 1. Date participant specific training will be completed |  |
| 9. | **Date of participant’s transition** |  |
| 10. | New provider presented new objectives and schedules, which will be included in the IPC modification. |  |
| 11. | Case manager updated EMWS and uploaded required documents into the Document Library at least seven (7) days before the transition is expected to take place:   * Update demographic information [change in location] * Upload Case Management Selection form [change in case manager] * Upload transition checklist * Upload Team Signature Verification form * Submit the modification |  |