|  |  |  |
| --- | --- | --- |
| **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).

|  |  |  |
| --- | --- | --- |
|  | **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. [ ]
 |
|  | 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. [ ]
 |
|  | 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. [ ]
 |
|  | 1. Projected units to be used through the transition date
 | 1. [ ]
 |
|  | 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. [ ]
 |
|  | 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. [ ]
 |
|  | 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
 |   |