Discharge Plan and Discussion Record

1.29.21

Meeting Date: Click here to enter a date.
DOB: Click here to enter date.
Levels of Mobility:
Ambulatory without support ☐; Ambulatory with support ☐; Uses wheelchair ☐; Total assistance ☐
Substitute Decision Maker: Click here to enter text.
Guardian ☐; Authorized Representative/SDM ☐

Training Center Social Worker: Click here to enter text.

Home CSB: Click here to enter text.

Individual: Click here to enter text.
Avatar Number: Click here to enter text.
Admission Date: Click here to enter a date.
Highest Level of Communication:
Spoken Language, fully articulates without assistance ☐;Limited spoken language, needs some staff support ☐; Communication device☐; Gestures ☐; Vocalizations ☐
Residential Manager/QIDP: Click here to enter text.

CSB Support Coordinator: Click here to enter text.

Please check all that apply:

☐ 30 Day Review ☐ 60 Day Review ☐ 90 Day Review ☐ Annual Review
☐ Initial Pre-Move ☐ Provider Pre-Move ☐ Final Pre-Move
☐ Special Circumstance related to discharge number # Click to enter number. (Only review barriers)

This form is to be completed at 30 day, 60 day, 90 day and annual reviews; pre move and special circumstance meetings. It is recommended that some of the sections on this form can and should be completed prior to the meeting for use as discussion points. TC Community and Social Services (CSS) staff should ensure that a copy of this form as well as the Communication Plan/Dictionary, ISP Parts II and IV, and event data are shared at the meeting for reference.

Did the individual participate in discharge planning?
☐Yes ☐No; if no, reason(s):

Did the Substitute Decision Maker/Guardian participate in discharge planning?
☐Yes ☐No; if no, reason(s):

Agenda

1. **Positive Attributes -** share the positive attributes you admire most about the individual.

A member of the TC CSS staff or the QIDP facilitates the annual reviews. A member of the TC CSS staff and Community Services Board Support Coordinator (CSB SC) co-facilitate pre-move meetings that occur at times other than the annual review. All PST members contribute by sharing what they like about the person; it is not talking about what the individual can/cannot do. For example – I like her sense of humor. It is very important to state something positive or what you have learned about the person.

2. **Personal Support Team and Individual discuss the Personal Profile (i.e. the Good Life, Talents/Contributions, Working/Not Working).** (*Pull up PC ISP Part II to refer to-Discharge Plan must be tied to Person-Centered Plan)*
   Good Life

This section must be completed at the annual review. For subsequent meetings and If the annual review was held within the previous three months or there have been no changes, include specific information that is helpful to the transition process. A statement of "See attached ISP" can be included. If there are changes, include the entire section here.

Good Life- Include information related to how, where and with whom the individual prefers to live. What things will be included in their life based upon their preferences?

Talents/Contributions

Talents/contributions – Use complete statements/sentences.

Working/Not Working

Working/Not Working – Use complete statements/sentences. Each section (Home; Community & Interests; Relationships; Work/Alternatives; Learning; Money; Transportation & Travel; Health and Safety) and related questions are pertinent and should be reanalyzed so that the most important information is included.

3. **Team decides on Important TO/Important FOR including protection from harm.** *(Pull up and refer to PC ISP Important To/For Outline):* Based on Review of the Profile, Comprehensive Functional Assessment (CFA) recommendations, (and/or other assessments). Must bring Event/Incidents Data for the last year & review analysis of event data *(i.e. hospitalizations, falls, aspirations, etc.).*

NOTE: Do not simply recite information from these forms. The TC QIDP and CSS staff work together to facilitate discussion about what had previously been noted, what has been learned since the last annual review, and how it is relative to the short-term goals of identifying the individual's preferences and needs and the type of supports that are required for him/her to live in their new community home.

Important to/for – If the annual review was held within the previous three months and/or there have been no changes, a statement of "See attached ISP" can be included. If there are changes, include the entire section here. At a minimum, include the issues identified as most important to/for the individual that impact the transition plan. Use complete statements/sentences.

Things that are Important To:

Things that are Important For:

INCIDENT REPORT SUMMARY FOR PAST YEAR

To ensure the individual's current status is evaluated and included in the planning, all event data/incident reports and other health-related data will be reviewed when completing this section. Emphasize those aspects that highlight the individual's desire for living in the community and the supports that are needed to enhance the likelihood of a successful move. (i.e. *Hospitalizations: where, when, # days, reason, how often and etc.)*

This section should be updated at each meeting

HOSPITALIZATION/ER VISITS:

# OF EPISODES	Details/Type of incident/injury and intervention required

(Code of Virginia - Sections 37.2- 837)

In the following section, be brief but concise and include information related to the supports that the individual is <u>currently</u> receiving. Based upon the "Important To(s)" and "Important For(s)" listed above, please specify if the person has skill development needs and recommend skill development activities.

<u>Code of Virginia - Sections 37.2- 837 states:</u> The discharge plan shall be contained in a uniform discharge document developed by the Department and used by all state hospitals, training centers, and community services boards or behavioral health authorities, and shall identify (i) the services, including mental health, developmental, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the individual will require upon discharge into the community and (ii) the public or private agencies that have agreed to provide these services.

Staffing Supports Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities
Supported employment/day options Currently has skill development needs? ☐Yes ☐No	(Note: Is individual currently employed or volunteering/how many hours?) Recommendations for skill development activities:
Environment Currently has skill development needs? ☐Yes ☐No	(i.e. space, accessibility, proximity to other people/shopping/roads/housing etc.) Recommendations for skill development activities:
Medical/nursing Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Mental health (Psychological/psychiatric/substance abuse) Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:

Behavioral Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Nutritional Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Physical Therapy Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Occupational Therapy Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Speech Language Therapy Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Communication (Communication Dictionary and outcomes developed by others who are not SLT.) Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Equipment Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Transportation	(Note: do not include driver when discussing staffing support during transportation) Recommendations for skill development activities:

Currently has skill development needs? ☐Yes ☐No	
Social (family, friends, volunteers, church) Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Recreational Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Financial (management of funds) Currently has skill development needs? ☐Yes ☐No	Recommendations for skill development activities:
Legal	
Advocacy/SDM Appointment	
Additional Comments	

4. Based on the assessment results, describe essential supports needed for transition to community based services.
(I.e. If the individual moves today, what supports does he/she need? Detail staffing needs for daytime, overnight, community etc. Which Department will complete the Specific Training for the providers?)
Be brief but concise, and include information related to the supports that are absolutely necessary and therefore indispensable to assist this individual to be successful and the individuals' health and safety

Essential Health and Safety Supports	**Training** *To be scheduled at provider pre-move meeting* **Choose dates below.**		
Group similar support needs together based on the following categories: *Staffing Supports, Type of supported employment/day placement/optimal length of day, Needs for the person's environment (space, accessibility, proximity to other people/shopping/roads, etc., Medical/nursing, Psychological/Psychiatric, Behavioral, Nutrition, Physical Therapy, Occupational Therapy,* Speech Language Therapy, *Communication (pain and distress), Equipment, Transportation, Social (family, friends, and volunteers, church), Recreational/Leisure, Financial, Legal, Advocacy/SDM Appointment*	**Scheduled**	**Completed**	**Training to be completed by (please enter the name and discipline)**

Staffing Supports	Click here to enter date(s).	Click here to enter date(s).	Click to name
Supported employment/day options	Click here to enter date(s).	Click here to enter date(s).	Click to name
Environment	Click here to enter date(s).	Click here to enter date(s).	Click to name
Medical/nursing	Click here to enter date(s).	Click here to enter date(s).	Click to name
Mental health (Psychological/psychiatric/substance abuse)	Click here to enter date(s).	Click here to enter date(s).	Click to name
Behavioral	Click here to enter date(s).	Click here to enter date(s).	Click to name
Nutritional	Click here to enter date(s).	Click here to enter date(s).	Click to name
Physical Therapy	Click here to enter date(s).	Click here to enter date(s).	Click to name
Occupational Therapy	Click here to enter date(s).	Click here to enter date(s).	Click to name

Speech Language Therapy	Click here to enter date(s).	Click here to enter date(s).	Click to name
Communication (Communication Dictionary and outcomes developed by others who are not SLT.)	Click here to enter date(s).	Click here to enter date(s).	Click to name
Equipment	Click here to enter date(s).	Click here to enter date(s).	Click to name
Transportation	Click here to enter date(s).	Click here to enter date(s).	Click to name
Social (family, friends, volunteers, church)	Click here to enter date(s).	Click here to enter date(s).	Click to name
Recreational	Click here to enter date(s).	Click here to enter date(s).	Click to name
Financial (management of funds)	Click here to enter date(s).	Click here to enter date(s).	Click to name
Legal	Click here to enter date(s).	Click here to enter date(s).	Click to name

Advocacy/SDM Appointment	Click here to enter date(s).	Click here to enter date(s).	Click to name
Additional Comments	Click here to enter date(s).	Click here to enter date(s).	Click to name

5. Team discusses rights restrictions.

The following rights restrictions were identified (e.g. Adaptive Clothing; Limited Access to Personal Hygiene Items; Sedation for Preventative Medical Care; Physical/Mechanical/ Pharmacological Restraints; Seat Belts and Bed Rails, Locked Doors.)**: Describe plans to address rights restrictions:**

Include information regarding the following:

- *Previous actions taken to lessen restrictions.*
- *Outcome of the use of these restrictions.*
- *Related formal support plans and their reviews.*
- *Consent status.*

6. Concerns – Use Chart below to explain concerns or any reasons the Individual, any team member, SDM or family member is reluctant to transition. If "yes" is selected under Barrier, please complete the Barrier Table below. Describe plans to address these concerns: (This must be updated, as needed at each meeting. Be sure to include dates for each step!)

Identify the specific issue with explanation.
Identify the person(s) with the issues by title, not name.
Include reference to actions taken by the team to address noted concerns, including the person(s) responsible and completion dates; this may include the need for a follow-up meeting by a specific date to review status.
This chart should be reviewed and updated at each meeting to include the date of the meeting/review.

Concerns	Plan/Steps to Address Concerns	**Barrier** Yes/No – meaning PST cannot resolve	Person Assigned	Due Date	Comments
		Choose one	Click to name	Choose date	Click to comment
		Choose one	Click to name	Choose date	Click to comment
		Choose one	Click to name	Choose date	Click to comment
		Choose one	Click to name	Choose date	Click to comment

**** If 3 viable options are not offered, list this as a concern**

This section should be completed to reflect information included on the RST referral.

Barriers related to Waiver Service Options or Other (Please use key below to identify barriers)

1.	Employment and Day Options	Select unavailable service	List multiple services and barrier #(s)
2.	Self-Directed Options (may be Agency Directed)	Select unavailable service	List multiple services and barrier #(s)
3.	Residential Options	Select unavailable service	List multiple services and barrier #(s)
4.	Crisis Support Options	Select unavailable service	List multiple services and barrier #(s)
5.	Medical and Behavioral Support Options	Select unavailable service	List multiple services and barrier #(s)
6.	Additional Options	Select unavailable service	List multiple services and barrier #(s)
7.	Other	Description	List corresponding barrier number(s)

Barrier Key (Choose all barrier numbers that apply and place in the applicable list above)	
1	Services not available under currently enrolled waiver
2	Services and activities unavailable in desired location
3	Community location is not adapted for physical access (not wheelchair accessible or ADA compliant)
4	Direct Support Staff- may not have experience or demonstrate competency to provide support with behavioral expertise
5	Direct Support Staff- may not have experience or demonstrate competency to provide support with mental health expertise
6	Direct Support Staff- may not have experience or demonstrate competency to provide support with medical expertise
7	Professional Behavioral staff- Psychiatric, PBS facilitator, Applied Behavioral Analyst, or other specialist unavailable
8	Professional Medical staff- Dental, nursing or any medical specialist unavailable
9	Accessible transportation unavailable
10	Individual/SDM/LG chooses less integrated option
11	Individual/Substitute Decision Maker (SDM)/Legal Guardian (LG) not interested in discussing/exploring options/refuses supports
12	Individual/SDM/LG does not choose provider after visit/still exploring community options
13	Frequent hospitalizations- medical and/or mental health hospitalizations
14	Delay in move and/or acceptance to a more integrated setting- due to unexpected or late medical interventions
15	Provider has determined placement is not a good match- provider is not willing/able to support individual
16	Service/Provider Development or Loss- Construction/Renovations/Environmental Modifications/Staffing/On-boarding/Licensing
17	Other (please list all other barriers below)

Comments :	

7a. All of the following types of residential options have been discussed with the Substitute Decision Maker(s) prior to beginning the active move process. Please provide the date(s) the discussions occurred with the SW, CSB SC and PST. Please note if preferred option(s) is only available out of the region where the individual wishes to reside:

*The CSB SC, TC CSS staff and other PST members will discuss **all** options available through the ID Waiver. All residential, questions/sections must be answered.*

Option	**TC CSS**	**Dates**	**CSB SC**	**Dates**	**PST**	**Dates**	**Service is only available out of region where the individual wishes to reside.**
Own Home (Rental Assistance Voucher)							
Leased Apartment (Rental Assistance Voucher)							
Family Home							
Sponsored Home							
Group Home (4 or fewer)							

Group Home (5 or more)							
ICF							
Nursing Home							
Training Center							
Other							

Was placement, with supports, in affordable housing, including rental or housing assistance, offered? ☐Yes ☐No; if no, reason(s):

TC CSS staff will ensure information regarding affordable housing is shared with SDMs/individuals. Additional information regarding the outcome of the conversation should be included in the Discussion section below. (#12)

7b. All of the following types of employment/day support options have been discussed with the Substitute Decision Maker(s) prior to beginning the active move process. Please provide the date(s) the discussions occurred with the SW, CSB SC and PST. Please note if preferred option(s) is only available out of the region where the individual wishes to reside:

*The CSB SC, TC CSS staff and other PST members will discuss **all** options available through the ID Waiver. All Employment and/or Integrated Day Activity questions/sections must be answered.*

Option	TC CSS	Dates	CSB SC	Dates	PST	Dates	Service is only available out of region where the individual wishes to reside.
Self-employment							
Individual Supported Employment							
Group Supported Employment							
Workplace Assistance							
Community Engagement							
Community Coaching							
Group Day Services							
Volunteer							
Retirement							
Other:							

Is the individual interested in employment? ☐Yes ☐No

If yes describe:

If no, reason(s):

What are the potential barriers to employment?

Individual/SDM was given information and opportunity to be referred to Department of Aging and Rehabilitative Services (DARs):

☐ No referral needed, not interested

☐ Yes information was given

☐ Yes, a referral to DARS was made

Date referred: Click here to enter a date. By whom? Click to name (Title) Click to enter title

8a. Potential Viable Community Residential Provider(s) Identified: At least one viable provider must be 4 beds or fewer. If the 4-bed option is outside of the preferred region, that option will be considered the 4th option.

Must include the number of beds, location and the date each option was offered to the SDM as well as the outcome.

1. Click here to enter provider

2. Click here to enter provider

3. Click here to enter provider

4. Click here to enter provider

5. Click here to enter provider

6. Click here to enter provider

7. Click here to enter provider

8. Click here to enter provider

9. Click here to enter provider

10. Click here to enter provider

Name, address and contact for Residential Provider selected: Click here to enter selected provider.

Be sure to include a contact number for the home as well as the name, number and email information for the main contact/manager/supervisor/etc.

Is the individual being served in the most integrated setting consistent with their informed choice and needs?

☐Yes ☐No; if no, reason(s):

Consider the individual's and SDM's choice and preferences. For example, if a family member would like the individual to live in a group home in a specific geographical location and the PST is unable to identify an option in that area, then the individual is not living in the most integrated setting consistent with their informed choice and needs.

8b. Potential Viable Community Employment/Day Providers – Virginia is an Employment First State which means Supported Employment must be offered as a first choice. An individual/SDM may decline such offer. Individual is "unable" to work is not an acceptable response; instead please document supports the individual would require to work successfully in the community.

Must include the location, date the option was offered as well as the outcome.

1. Click here to enter provider

2. Click here to enter provider

3. Click here to enter provider

4. Click here to enter provider

5. Click here to enter provider

6. Click here to enter provider

Name, address and contact for Employment/Day Provider selected: Click here to enter selected provider.

Be sure to include the contact number for the location as well as the name and contact information for the manager/supervisor/etc.

Please check all services that apply.

☐ Individual Supported Employment ☐ Group Supported Employment

☐ Workplace Assistance Services ☐ Community Engagement

☐ Community Coaching ☐ Group Day Services

8c. Discuss and review other identified community Providers (Dental, Specialist, Durable Medical Equipment (DME), Pharmacist, Psychiatrist/Behavioral Specialist (Positive Behavioral Support Facilitator (PBSF), Applied Behavioral Analyst (ABA), etc.), REACH Coordinator, Developmental Disabilities Health Service Network (DDHSN) etc. if applicable. *Please attach specialist form*.

Include a list that includes the address and contact information for each community provider. This section should be completed by the Final Pre Move Meeting.

9. Provider type requiring CIM review

Provider Type Requiring CIM Review			
Type of Program Chosen	**Choose one (indicate Yes/No)**	**Reasons Identified for choosing home or not choosing Employment/ Day Options**	**Actions taken** Note: If a move to a residence serving five or more individuals was recommended, referral to the Regional Support Team (RST) will be made to identify barriers to placement in a more integrated setting
5 or more individuals served in a home	Choose an item.		
ICF/ID	Choose an item.		
Nursing home	Choose an item.		
More than one (1) program on a site	Choose an item.		
Employment not chosen	Choose an item.		
Day Options not Identified	Choose an item.		
Retired	Choose an item.		

**** If any of the above are "yes" –CIM or Designee must complete and submit an RST referral form**

☐ RST Referral form will be completed

Date referred: Click here to enter a date. By whom? Click to name (Title) Click to enter title

RST Follow Up Information:

☐ RST Referral form does NOT need to be submitted at this time.

If a move to a residence serving five or more individuals was recommended, did the Personal Support Team (PST) and, when necessary, the Regional Support Team (RST) identify barriers to placement in a more integrated setting? ☐ Yes ☐ No; if no, reason(s):

10. Referrals

REACH - Individual/SDM was given information about REACH and opportunity to be referred to REACH for assessment**.**

The PST, including the SDM, should discuss the need for REACH services for all individuals in the discharge process who have a current behavior support plan. If it is determined that REACH services are needed, the TC CSS staff should make a referral prior to discharge to allow REACH participation in Pre Move Meetings and the discharge process.

☐ Yes, information was given.

☐ Yes, a referral to REACH was made.
Date referred: Click here to enter a date. By whom? Click to name (Title) Click to enter title

☐ N/A – individual does not currently have any need for REACH services.

☐ Individual/Family did not choose REACH services.

FAMILY RESOURCE CONSULTANT - Individual/SDM was given information about Family Resources (all individuals/SDMs MUST receive information) and was offered a chance to be referred to the Family Resource Consultant for connection to the following options.

Confirm SDM receipt of information regarding FRC services and the date of referral

☐ Yes, individual/SDM received community resource materials and was offered to be referred to the Family Resource Consultant – (This should always be checked as we have an established packet that is sent to all SDMs as well as a packet that is given to individuals/SDMs at each annual and initial pre-move meeting).

☐ Yes, a referral to the Family Resource Consultant was made.
Date referred: Click here to enter a date. By whom? Click to name (Title) Click to enter title

☐ Yes, individual/SDM wants to speak with other individuals with ID/DD who live and work successfully in the community.

☐ Yes, individual/SDM wants to speak with family members of individual with ID/DD who live and work successfully in the community. (Community Living Contacts - One time discussion)

☐ Yes, individual/SDM would like a Family Mentor.

☐ Yes, individual/SDM would like a Peer Mentor.

☐ Individual/SDM not interested in any referrals.

Confirm SDM's preferred method of contact

SDM prefers to be contacted by:

☐ **Name:** Click here to enter name.

☐ **Phone:** Click here to enter phone number.

☐ **Email:** Click here to enter email address.

☐ **Mail:** Click here to enter mailing address.

☐ **Home visit:** Click here to enter home address.

11. Discharge process confirmation: Important to note that the move process is an individualized process. Some individuals may move in a shorter or longer period of time. However, every individual will be given a targeted move date and PST members must provide clear documentation/justification of changes in move dates and steps taken to address delays. This would be documented either under concerns/barriers, as appropriate.

When	Event	Date to be completed	Tasks	Comments

Week 1	Initial pre-move meeting		Sign DP/DR form within 48 hours of meeting; send DP/DR form to CSB/ Provider/SDM within 72 hours	
Week 2	Choose providers to tour		Schedule tours with individual/SDM/TC/ Family/Providers	
Weeks 3/4	Provider tours		Tour provider locations	
Week 5	Provider Assessment on site		Provider completes onsite assessment of individuals	
Week 5	Providers selected to visit		Send PIR to CRC/OHR/OL within 1 day of choice(s); complete PIRs within 6 days Complete Onsite Provider Shadowing preferably by date of meeting and prior to specific training.	
Week 6	Special Circumstance as needed: Number of SC		Send DP/DR for Special Circumstance Pre-move meeting to CSB/Provider/SDM within 72 hours prior.	
Week 6	Provider pre-move meeting		Send DP/DR for Provider Pre-move meeting to CSB/Provider/SDM within 72 hours prior.	
Week 7	Day visit		Complete Day Visit Form with 48 hours	
Week 8	Evening visit		Complete Evening Visit Form within 48 hours	
Week 9	Provider Training and Final/overnight visit		Complete Provider Training prior to overnight visit. Complete Final/Overnight Visit Form within 48 hours	
Week 10	Final pre-move meeting or Special Circumstance as needed		Send DP/DR for Final Pre-move Meeting to CSB/Provider/SDM within 72 hours prior	
Week 12	Move to new home.		Enter Discharge Date	
PMM 1	Schedule (announced) PMM visit by day 3		Share PMM Report, Review expectations of PMM visits, Schedule PMM visits from TC	
PMM 2	Schedule (announced) PMM visit by day 10		Share PMM Report, Review expectations of PMM visits, Schedule PMM visits from TC	
PMM 3	Schedule (announced) PMM visit by day 17		Share PMM Report, Review expectations of PMM visits, Schedule PMM visits from TC	
PMM 4	Schedule (announced) PMM visit between days 30-60		Share PMM Report, Review expectations of PMM visits, Schedule PMM visits from TC	

**** For below General Discussion area, include any recommendations received by OHR/OLS from the PIR and plans to address or reasons why recommendations do not need to be addressed.**

Name: Avatar Number: Meeting Date:

Include information regarding discussion points and details not otherwise addressed in this document. A summary of what occurred during the meeting as well as a list of identified action items and responsible parties should be included for each meeting. Action items from the previous meeting should be reviewed and the status noted in this section at the subsequent meeting.

12a. General Discussion Annual Meeting:

12b. General Discussion Initial Meeting:

12c. General Discussion Special Circumstance Meeting (if needed):

12d. General Discussion Provider Pre-Move Meeting:

12e. General Discussion Final Meeting:

13. Confirmations:

CSB SC is reminded of responsibility to make appropriate notifications. The CSB SC will confirm notification for documentation in DPDR when completed.

CSB SC notifies receiving CSB when a selected provider is outside of home CSB region. ☐Yes ☐No ☐N/A

TC CSS staff is responsible for providing the documents listed below. Confirmation of receipt should be documented.

CSB received updated documents or requested documents from TC partners. ☐Yes ☐No ☐N/A

Provider received updated documents or requested documents from TC partners. ☐Yes ☐No ☐N/A

Provider received safety alerts. ☐Yes ☐No

For Annual Review only:

14. Team develops shared goals and discusses outcome priorities for ISP Year. ***(PC ISP Location: Part V)***

Include any short- and long-term goals and plans for skill enhancement, medical or other assessments, etc.
These include those actions to be taken by the individual, Team and/or CSB between the meeting date and placement date.
These may include:

- *Specific short-term goals or outcomes for skill acquisition;*
- *Specific medical assessments/procedures;*
- *Specific opportunities for exposure to certain aspects of community living; or*
- *A continuation of current active or support outcomes.*

15. Team reviews the individual planning questions in Part IV and explains any "No" selected from the list and signs in agreement. *(PC ISP Location: Part IV and Signature Page)*
Review ISP Part IV
Annual

For Final Pre-Move Meeting

16. Final Pre-Move Meeting
Was the SIS completed? ☐Yes ☐No; if no, reason(s): Date: Click here to enter a date.

Have the CSB and community provider(s) confirmed there is a *Waiver Plan for Supports* in place that meet the essential supports identified in the *Discharge Plan and Discussion Record?* ☐Yes ☐No; if no, reason(s):

Have the CSB and community provider(s) agreed to provide a copy of the *Waiver Plan for Supports* that meet the essential supports identified in the *Discharge Plan and Discussion Record after completion?* ☐Yes ☐No; if no, reason(s):
Plan to be submitted to: Click here to enter text.

Has the CSB Support Coordinator (CSB SC) confirmed an agreement between the CSB and community provider(s) regarding which supports have been submitted for approval through WaMS based on individual's needs which are outstanding? ☐Yes ☐ No; if no, reason(s):

Has attendance been confirmed for community provider(s)/representatives in mandatory trainings as applicable?
☐Yes ☐No; if no, reason:

Have the CSB and community provider(s) confirmed that all essential supports listed are in place prior to move date?
☐Yes ☐No; if no, reason(s):

Has the SDM appointment for community partners been confirmed? ☐Yes ☐No; if no, reason(s):
CSB: Click to enter the name of SDM
Residential Provider: Click to enter the name of SDM
Employment/Day Provider: Click to enter the name of SDM
Appointment paperwork received for DC file: Choose an item.

Have the community provider(s) been informed of their responsibility to follow guidelines regarding reporting to Office of Licensing, Office of Human Rights and the Community Services Board? Provider(s) also informed that they must provide timely notification to TC Post Move Monitoring Coordinator or CIM designee regarding change of address, change of telephone number, change of day /employment provider, any illness/ hospitalization or injury requiring medical treatment after an individual has moved. ☐Yes ☐No; if no, reason(s):

Was the discharge plan updated within 30 days prior to the individual's transition? ☐Yes ☐No; if no, reason(s):

Was community provider staff trained in the individual support plan protocols that were transferred to the community?
☐Yes ☐No; if no, reason(s):

Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists? ☐Yes ☐No; if no, reason(s):

Are all essential supports in place before the individual is scheduled to move? ☐Yes ☐No; if no, reason(s):

Does the discharge plan (including the Discharge Plan Memo completed following the final meeting) list the key contacts in the community, including the licensing specialist, Human Rights Officer, Community Resource Consultant and CSB supports coordinator? ☐Yes ☐No; if no, reason(s):

☐ Check box if move has **NOT** occurred within 6 weeks after final visit to home. *(list this as a barrier in the above barrier chart)*