|  |
| --- |
|  |
| **Person Making Request**  |        | **Date Emailed to Region(s)**  |       |
| **Targeted Move Date** |        |
|  |  |  |  |
|  | [ ]  **CareStar** [ ] **Creative** [ ] **GA Supports** [ ] **Professional** [ ]  **Benchmark** [ ]  **Compass**[ ]  **Columbus** [ ]  **PLA** [ ]  **SSC** |

#  Current Information:

|  |  |  |  |
| --- | --- | --- | --- |
| **Originating Region:**  |  | **Forward to R2R Box**  |  |
| **Receiving Region:** |  | **Forward to R2R Box** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Individual Information:****CID#**       |        |        |        |
| *First Name* | *Middle Name* | *Last Name* |
| **Birth date:**  |       | ***Active******SSI/SSDI:*** | [ ] Yes[ ] No | ***Active Medicaid#:*** |       |
| **Current Contact Information** |        |        |
| *Address:* | *City:* |
|       |        |        |        |
| *County* | *State* | *Zip code* | *Telephone#:* |
| Does the individual have a legal guardian that is involved? [ ]  Yes [ ]  Has GA court guardianship documents been uploaded in IDD-C? [ ]  Yes [ ]  No  |
| **Request for Location Change:** | [ ]  **Individual** [ ]  **Family**  |  | [ ]  **Provider** |  |
| **Reason(s) for Transfer:** | [ ]  **Closer to family** [ ]  **Conflict with staff** [ ]  **Conflict with housemates** [ ]  **Conflict with neighbors**[ ]  **Issue with Law Enforcement**  | [ ]  **Issue with services/care** [ ]  **Dissatisfied with location**[ ]  **Environmental Issues** [ ]  **Investigation Conflict with staff**[ ]  **Other (*explain with detail*)**  |  |  |
|  |  |  |  |  |  |  |  |  |  |

# Current Provider (if more service lines are needed additional space available on page 5.):

|  |  |
| --- | --- |
| **Current Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| **Current Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| **Current Provider:** |        |
| Address: |        |
| Telephone #: |         |
| Service: (CRA, CLS, etc.) |        |
| **Current Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |

# New Provider Information: (if more service lines are needed additional space available on page 5.):

|  |  |
| --- | --- |
| **New Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| Residence address if different from Provider Address  |        |
| **New Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| CLA/HH Address if different from above |  |
| **New Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| **New Provider:** |        |
| Address: |        |
| Telephone #: |       |
| Service: (CRA, CLS, etc.) |       |

# Waiver Information:

|  |  |
| --- | --- |
| Funding Source: | [ ] NOW [ ] COMP[ ] Other      |
| DMA-6/DMA-7 Current Date: |       | *Next Due Date:* |       |
| ISP Current Date: |       | *Next ISP Due Date:* |       |

# Transfer Documents:

|  |  |  |  |
| --- | --- | --- | --- |
| ***Documents Review:*** Please assess and submit documents so that they are available for this transfer. | **Documents Needed** | **Date Document Signed** | **Document Uploaded Into IDD Connect** |
| [ ]  **Current DBHDD Release**  |       |       |
| [ ]  **Current Freedom of Choice**  |       |       |
| [ ]  **Current My Human Rights**  |       |       |
| [ ]  **Current MOU (PD)**  |       |       |

|  |  |
| --- | --- |
| ***Did the individual and/or family visit the home?*** [ ]  Yes [ ]  No | If so, what was the date of the visit?      Are there other individuals in the home? [ ]  Yes [ ]  No Has Housemate Matching Form been submitted? [ ]  Yes [ ]  No  |
| **New Provider Preparation** | **Does the individual have a:**[ ] Behavior Support Plan [ ]  Yes[ ]  No Dates of Plan:[ ] Crisis Safety Plan [ ]  Yes[ ]  No Dates of Plan:[ ] Health Care Plan [ ]  Yes [ ]  No Dates of Plan:[ ] Nursing Assessment [ ]  Yes [ ]  No Dates of Plan:[ ] Social Work Assessment [ ]  Yes [ ]  No Dates of Plan:**If so, have the plans been submitted for review and accepted by the potential new provider:** [ ]  Yes[ ]  No Date Accepted:**Please list current behaviors displayed by the individual:****Please list any major behaviors displayed in the past that could resurface during a move:** |
| **Has the new provider reviewed clinical documents?** [ ] Yes[ ] No[ ] HRST[ ] Yes[ ] No [ ] SIS[ ] Yes[ ] No[ ] Nursing[ ] Yes[ ] No[ ] CABS[ ] Yes[ ] NoRevised HRST/SIS if needed?[ ]  Yes[ ] NoHas the new provider received current list of prescribed medication(s) from pharmacy?[ ] Yes[ ] No |
| Does the person have or need enhanced supports? Please explain:      Has Immediate and Critical request been approved? [ ]  Yes[ ] NoWhat environment has the additional staffing been approved?       CRA       CLS       CAGWhat is the end date for the additional staffing?       |
| Does the person have skilled nursing needs? Please explain:Does the person require a wheelchair or have other accessibility requirements?  |
| What are the current support needs (i.e. special diet, assistance walking, etc.) of the individual?    |
| Is this individual transitioning from a state hospital? [ ] Yes[ ] NoIs this individual transitioning from a community hospital? [ ] Yes[ ] NoIs this individual transitioning from a crisis home? [ ] Yes[ ] No Is Crisis ISC in place after discharge? [ ] Yes[ ] NoIs this individual part of the ADA settlement class? [ ] Yes[ ] No |
| **Training of New Provider or New Home Staff** | List all training completed by new provider and dates based on ISP, HRST, and current clinically assessed needs.  |
| **Information reviewed with Support Coordinator/Planning List Administrator** | [ ]  Yes [ ]  No Date: |

**REGIONAL OFFICE USE ONLY**

**TFC**

|  |  |
| --- | --- |
|  | **If** **individual is part of the ADA settlement class has TFC approved this move? (**[ ]  **Yes** [ ]  **No)** |

**Originating Regional Office Approval**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Submitted to Region: |  | *Date Approved by Region:* |  |
| ***Approved By:*** (Name and Title) |  |

**Receiving Regional Office Approval**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Submitted to Region: |  | *Date Approved by Region:* |  |
| ***Approved By:*** (Name and Title) |  |
| ***Date provider submitted PPSV: (If applicable)*** | **Date:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Provider Site Inspection**  |  | **PPSV Completed By:** |  |

# Additional Current Providers (please copy and paste an additional line if more service lines are needed)

|  |  |
| --- | --- |
| **Current Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| **Current Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| **Current Provider:** |        |
| Address: |        |
| Telephone #: |         |
| Service: (CRA, CLS, etc.) |        |

# Additional New Provider Information: (please copy and paste an additional line if more service lines are needed):

|  |  |
| --- | --- |
| **New Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| **New Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| **New Provider:** |        |
| Address: |        |
| Telephone #: |        |
| Service: (CRA, CLS, etc.) |        |
| **New Provider:** |        |
| Address: |        |
| Telephone #: |       |
| Service: (CRA, CLS, etc.) |       |