|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **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:*** | | YesNo | | ***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 COMPOther | | |
| 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?** YesNo  HRSTYesNo  SISYesNo  NursingYesNo  CABSYesNo  Revised HRST/SIS if needed? YesNo  Has the new provider received current list of prescribed medication(s) from pharmacy?YesNo |
| Does the person have or need enhanced supports? Please explain:  Has Immediate and Critical request been approved?  YesNo  What environment has the additional staffing been approved?        CRA       CLS       CAG  What 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? YesNo  Is this individual transitioning from a community hospital? YesNo  Is this individual transitioning from a crisis home? YesNo  Is Crisis ISC in place after discharge? YesNo  Is this individual part of the ADA settlement class? YesNo |
| **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.) |  |