



## LIGAS TRANSITION SERVICE PLAN

### See instructions for completion of the Transition Service Plan

**Note:** Information must be typed, not hand-written.

Name of Individual: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Type of Current Residence: \_\_\_\_\_

(Family Home, ICF/DD)

**Current Daytime Activity (Describe a typical day, including routine, activities and settings):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Home Supports (Service description, # of hours, if applicable):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of Guardian: \_\_\_\_\_ If no Guardian, enter "Self".

Relationship to individual: (family, friend, OSG, other): describe: \_\_\_\_\_

Type of Guardianship: \_\_\_\_\_

City / County of Guardian's Residence: \_\_\_\_\_

Telephone Number: ( \_\_\_\_ ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

(SEE BELOW FOR CO-GUARDIANSHIP)

Name of Guardian: \_\_\_\_\_ Type of Guardianship: \_\_\_\_\_

City / County of Guardian's Residence: \_\_\_\_\_

Telephone Number: ( \_\_\_\_ ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**IF NO GUARDIAN, FAMILY CONTACTS: (release(s) on file for family members, friends, etc.)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone Number: ( \_\_\_\_ ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Family Member City / County Residence: \_\_\_\_\_



## LIGAS TRANSITION SERVICE PLAN

INDIVIDUAL'S NAME: \_\_\_\_\_

Current ISC Agency: \_\_\_\_\_

Transition Plan Completed by (ISC AGENT): \_\_\_\_\_ Plan Completion Date: \_\_\_\_\_

Address: \_\_\_\_\_

Office Phone: ( \_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_ ) \_\_\_\_\_ Fax Number: ( \_\_\_\_ ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

### 1. Personal Background and Social Summary (1-paragraph)

Provide a one-paragraph overview of the individual including a brief summary of the person's background, skills, and abilities, current services (e.g., ICF/DD, Adult Home Based Services), living situation and family. The purpose of the summary is to help the reader of the LTSP quickly gain a picture of the individual). (See Example in LTSP Instructions)

### 2. Where do you want to live?

(City, county, or geographic region; near friends, relatives, easy access to public transportation, desire to learn skills to use public transportation, near employment, near day time activity, recreational services)

### 3. Preferred living arrangement?

(With family, alone in own apartment, in an apartment with roommates, in 24-hour supervised group home, identify risk factors)



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### **4. Is there anyone you would like to live with or prefer not to live with?**

(Friendships, potential housemates. List preferences regarding sharing a bedroom, roommates, and housemates).

### **5. Preference of Employment, Earning Money, Volunteering, Alternative Day Activity, Continuing**

**Education:** (job coaching, supported and customized employment, the discovery process, self-employment.

Describe past job experience and desire for future employment training or day activities, vocational opportunities, identify risk factors)

### **6. Community Opportunities:**

**Participation in Community Life:** Focus on preferences, strengths, and needs. Identify services and supports to be integrated into the community to the maximum extent possible in order to gain a presence in the community (e.g., medical services, beautician/barber services, recreational, educational, social activities, shopping, movies, theatre, health services, fitness center, community access - including the desire to utilize public transportation, and pedestrian skills). Identify risk factors. Provide detail of activities currently engaged in and future desired activities.



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### **7. Personal Preferences:**

This section is intended to identify personal likes and dislikes of the individual. The current and future vision/hopes should be identified and addressed in detail to summarize desire and choice. Discussion shall focus on likes and dislikes in a variety of settings and aspects (e.g., home, community, social, recreational, spiritual, and educational opportunities).

### **8. Family Involvement / Relationships:**

Summarize relationships which support personal success, including extended family members. Identify relationships which may pose an obstacle in gaining independence.

### **9. Communication Skills:**

Method of Communication, Style of Understanding. (e.g., preferences and choices on how the person communicates and with whom). Include present, past and/or needed use of Assistive Technology, Augmentative Alternative Communication Devices (AAC). Identify communication assessments and/or therapies provided currently or in the past. Identify risk factors. Risk factors could include but are not limited to the ability to express the need for medical attention or emotional supports).

For further detail, communication assessments and reports, if available, should be referenced and/or attached.



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### **10. Mobility:**

(Assistance needed in transferring, adaptive equipment used and/or needed, accessible living arrangement) Identify risk factors. Risk factors could include but are not limited to falls/fractures, use of stairs/escalator/elevator, accessing a motor vehicle, fire evacuation, and issues related to physical status - obesity, shortness of breath, weakness, and skin breakdown.

For further detail, mobility assessments, fall prevention plans and reports, if available, should be referenced and/or attached.

### **11. Personal Care:**

(Meal Preparation, eating, hygiene, bathing, dressing, household chores, repositioning, level of support, identify risk factors)

### **12. Meal Time Assistance:**

(Summarize the level of supports needed at meal times. Include adaptive equipment, if any) Identify risk factors. Risk factors could include but are not limited to choking and/or aspiration, swallowing disorders, postural support, potential for injury, and behavioral support.

For further detail, clinical assessments and reports, if available, should be referenced and/or attached.



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### **13. Special Dietary Needs:**

Summarize restrictions and/or supports which will ensure dietary needs. Identify risk factors. Risk factors could include but are not limited to significant weight loss or gain, allergies, and likes/dislikes in food preferences. For further detail, dietary assessments and reports, if available, should be referenced and/or attached.

### **14. Personal Decision Making:**

(Ability to make decisions, Level of support needed in making decisions)

Summarize decisions the individual does make and situations when personal decision-making can be maximized (e.g., Money skills, banking, ability to make purchases, scheduling, meal preparation, community access, giving direction, following direction, time management, attention to task, participation, religion, and leisure activities). Identify risk factors. Risk factors could include but are not limited to money management skills, risk of financial exploitation, social/friendship choices, telephone usage, comprehension and processing skills, and television/movie viewing.

### **15. Adaptive Equipment / Protective Equipment:**

Summarize provided and/or needed equipment or resources which increase independence or maintain safety (e.g., Hearing aids, glasses, wheelchairs, walkers, safety helmet, plate guard, Hoyer lift, etc.). Communication devices should be detailed in the Communication Skills domain. The use of adaptive/protective equipment should be supported in the Medical/Physical Well-Being domain. Risk factors associated with adaptive/protective equipment should be listed.



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### **16. Behavior Support Needs:**

(Supports needed for specific behaviors)

Include summary of behavior, frequency, severity, antecedents, duration, successful intervention, last episode and any mental health needs, including history of psychiatric admissions. Identify risk factors.

For further detail, a Behavioral Plan, if available, should be attached.

### **17. Medical / Physical Well-Being:**

(Healthcare supports needed, identify risk factors)

Summarized medical history, chronic medical conditions, consequences, and services for support. Include need for physical, occupational and other therapies. Risk factors could include but are not limited to sensory impairments, frequent falls, compliance towards recommendations, significant number of medical visits, inability to tolerate a medical examination/procedure, perceived linkage of medical professionals.

For further detail, assessments and reports, if available, should be referenced and/or attached.

### **18. Medications:**

(Does the individual take his/her own medication without assistance? What assistance is the individual currently receiving? Identify risk factors)

Include a summary list of medications.



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### **19. Legal Issues:**

**(Court/police involvement, Guardianship, Trust Fund Issue)**

### **20. "Other Risk" Not Identified Above or Human Rights Restrictions:**

**(Community Access, History of traumatic events, Assessments)**

Detail human rights restrictions such as limitations on visiting, food, room locks, behavioral interventions, etc. Summarize traumatic events such as bullying, neglect, abuse (physical, mental, sexual) that may interfere with a person's ability to engage or interact appropriately.

### **21. Summary of Past Transition and/or Supports**

**(Current/Past Services & Supports, Social Summary, Residential History)**





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### **22. Support Needs and Time Table for Transition**

(Day visit, overnight, dinner visit, adjustment period, familiarization with staff, and a schedule summarizing the transition process will be developed).

### **23. Transition to new ISC Agency, if applicable.**

(Document new ISC agency, purpose of transfer, date of informing new ISC agency, planned date of transfer)

### **Participation:**

Date the ISC met with the individual: \_\_\_\_\_.

Date the ISC met with the guardian, if applicable: \_\_\_\_\_.

Describe Class Member's participation in the plan:

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INDIVIDUAL'S NAME: \_\_\_\_\_

**People who participated in the development of the plan:  
(The ISC should document efforts to resolve any barriers limiting participation).**

The ISC should ensure that participant's names are entered in the signature block below.

Printed Participant's Name	Title
	Individual
	Guardian (If Applicable)
	ISC (QIDP)



## **LIGAS TRANSITION SERVICE PLAN**

INDIVIDUAL'S NAME: \_\_\_\_\_

### **Approval of Transition Service Plan**

<b>Printed Name</b>	<b>Signature</b>	<b>Date</b>	<b>Title</b>
			<b>Individual (signature or mark)</b>
			<b>Guardian(s) (If Applicable)</b>
			<b>ISC</b>
			<b>Other (detail)</b>

**If the Class Member is unable to sign, so indicate.**