



***Ligas* Transition Service Plan Instructions**

A *Ligas* Transition Service Plan (LTSP) shall be developed specific to, and centered on, each *Ligas* Class Member (*Ligas* Consent Decree, Paragraph 10). For individuals presenting a crisis situation, refer to the Crisis Transition Plan.

The *Ligas* Transition Service Plan is a formal document. It must be typed, not hand-written.

The *Ligas* Transition Service Plan may be supplemented with a Person Centered Plan (PCP), such as a Relationship Map. Completion of the *Ligas* Transition Service Plan does not eliminate the need for a provider to complete a service plan within 30 days after an individual's entry into a waiver program. A provider has a responsibility for completing a reassessment of risk with recommendations after the individual has transitioned to the provider's services. Plans to mitigate the assessed risk will be incorporated into the service plan developed by the provider.

Ligas Transition Service Plan development should focus on the individual's personal vision, preferences, strengths and needs in home, community, and work environments. The plan shall reflect the value of supporting the individual with relationships, productive work, participation in community life, and personal decision-making. (*Ligas* Consent Decree, Paragraph 13)

The *Ligas* Transition Service Plan will be developed by a Qualified Intellectual Disabilities Professional (QIDP) employed by the Independent Service Coordination (ISC) agency with geographical jurisdiction in conjunction with:

- Individual;
- Individual's legal guardian, if applicable;
- Individual's family members;
- Friends;
- Support Staff [This person is familiar with the Individual and could be staff from current service (Home Based Services, ICF/DD) and would have valuable input].

A *Ligas* Transition Service Plan is required for those individuals who are leaving an ICFDD or leaving their own or family's home to receive services.

The development of the *Ligas* Transition Service Plan shall be held face-to-face between the individual and the QIDP. It is imperative that the individual be given a choice on selecting the participants involved in the *Ligas* Transition Service Plan. The location of guardian, family members, and other members contributing to the plan may require exceptions being made for telephone participation. In order to obtain sufficient documentation, the transition planning process may require more than one meeting/contact, in order to obtain input from different contributing participants.

The *Ligas* Transition Service Plan shall:

- Describe the services the individual requires in a community-based setting or through community-based services;
- Include where and how such services can be developed and obtained;
- Include supports and services the individual will need during his or her transition to a community-based setting;
- Identify the timetable for completing the transition.

All services and supports in the *Ligas* Transition Service Plan must be integrated into the community to the maximum extent possible, consistent with the choices of the individual and where applicable, the individual's legal guardian. (*Ligas* Consent Decree, Paragraph 14)

The *Ligas* Transition Service Plan shall not be limited by current availability of services. It should be understood that no obligation is made to provide the types of services beyond those included in the Waiver and/or the State Plan. (*Ligas* Consent Decree, Paragraph 15)



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The *Ligas* Transition Service Plan should be developed through dialogue involving the Individual, Individual's legal guardian, if applicable, Individual's family members, friends, and support staff who are familiar with the individual.

The *Ligas* Transition Service Plan is not intended to duplicate information. Assessments and reports can be attached to provide further details of specific needs (e.g., psychological, ICAP, MAR). Note: Any serious needs or health risks should be clearly documented in the plan.

Within no more than twelve months prior to the development of a *Ligas* Transition Service Plan, the individual and/or guardian, in an objective manner, will be presented all of his or her service alternatives. A *Ligas* Transition Service Plan exceeding 12 months from service initiation must be updated. The *Ligas* Transition Service Plan shall be completed within sufficient time to provide appropriate and sufficient transitions of individuals in accordance with the deadlines set forth in the Decree. (*Ligas* Consent Decree, Paragraph 16)

The *Ligas* Transition Service Plan shall be initiated as individuals are selected to receive Medicaid Waiver services through the Prioritization of Urgency of Need for Services (PUNS) or a request is received reflecting a choice of Waiver services (e.g., Individuals residing in private ICFs/DD with nine or more residents).

Guidance for Service Plan Completion:

- When completing the transition plan, staff should document when an individual's preference and choice on a specific issue is of special importance to them.
- The format of the transition service plan should not be used as a script. Information should be gained through conversation and dialogue.
- When referencing a person seeking services, staff should refer to the person by name or use "individual" to ensure consistency.
- Staff should be clear in their distinction between using terms such as "housemate" or "roommate". A roommate is someone sharing a bedroom. A housemate is someone residing in the same residence.
- Avoid the use of broad statements such as structured chores, shopping, and going out to eat. Specifics should be used to define individual preferences and choices.

Use of the *Ligas* Transition Service Plan:

The transition plan should be included in all referral packets sent to potential service providers. A potential provider should closely review the individual's preferences, choices, and needs. As a provider is selected, the ISC, through the ISP approval process, will ensure the *Ligas* Transition Service Plan (LTSP) is utilized in completing the Individual Service Plan (ISP). The LTSP should be used as a foundational tool for development of the ISP, in addition to other assessments.

Who should retain copies of the *Ligas* Transition Service Plan?

- Individual and/or Guardian
- ISC Agency completing the LTSP
- Receiving ISC Agency
- Residential Provider
- Day Services Provider
- Service Facilitator

Service Plan Completion:

Name:

Record individual's legal name as it would appear on a service funding packet. This area of the *Ligas* Transition Service Plan should also reflect any common names or nicknames.



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Address: Current Residence

Type of Current Residence:

Describe current residence by setting and/or service type.

Current Daytime Activity:

What type of structured activity does the individual engage in during the day? (e.g., school, work, social settings, recreational program, or day program) Describe a typical day in the life of the individual, including typical routines, activities, and settings.

Home Supports:

(Type of supports and # of hours, if applicable.)

Date of Birth (DOB):

Record DOB (MM/DD/YYYY). Ensure individual is age 18 or older for established eligibility.

Guardian:

If an individual retains his/her own rights, enter "Self". The *Ligas* Transition Service Plan should state in summary that the individual retains his/her own rights. The *Ligas* Transition Service Plan document has made accommodations to reflect those having co-guardians. If no guardian has been assigned, the individual may choose to involve someone to assist with *Ligas* Transition Service Plan development. These individuals should be listed and a consent form/release of information completed to allow contact.

ISC:

Record the Independent Service Coordination (ISC) agency having geographical jurisdiction. The *Ligas* Transition Service Plan shall reflect the ISC agent that completed the *Ligas* Transition Service Plan and contact information for that person. The ISC must enter the date the *Ligas* Transition Service Plan was completed.

Personal Background and Social Summary:

Provide a one-paragraph overview of the individual including a brief summary of the person's background, skills, 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.

Example: Jill is a 32-year old woman who has lived at Robertson ICF/DD for the past 8 years. She attends Jones DT sheltered workshop 5 days a week. Previously, Jill lived with her parents and 2 siblings in Joliet. She attended Spruance School until she aged out at 21. Jill is non-verbal and communicates with gestures and signs. She uses a motorized wheelchair for travel. Jill needs assistance and support with her ADL activities. She wants to work and earn money and would need assistance from a job coach.

Where do you want to live?

Record the desire to live near a friend, group of friends, or others. Description should be provided to narrow choice to a geographical area of the state (e.g., Within 20 minutes or 5 miles of a desired person, close to public transportation, desire to learn skills to use public transportation, community resources).

Preferred Living Arrangement:

Describe setting/choice of residence (e.g., with family, alone in own apartment, in an apartment with roommates, in 24-hour supervised group home with housemates, etc). Identify risk factors which may include but are not limited to environmental hazards, personal safety, others in the home, emergency situation response, and chemicals/cleaning products.



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Is there anyone you would like to live with or prefer not to live with?

List preferences regarding sharing a bedroom, roommates, and housemates. Summarize dialogue addressing desires to maintain/establish friendships or social relationships with action steps to achieve. Is there someone you would prefer as a housemate or roommate? Is there someone you would prefer not to live with?

Preference of Employment, Earning Money, Volunteering, Alternative Day Activity, Continuing Education:

Work activities the individual would like to engage in (e.g., job coaching, supported and customized employment, the discovery process, self-employment, vocational opportunities, competitive employment, and developmental training.) Describe past job experience and desire for future training. Identify risk factors which may include but are not limited to conflict resolution with others, use of tools and equipment, avoidance of dangers associated with tasks, and dangers posed by other persons at the worksite.

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, and pedestrian skills). Risk factors could include but are not limited to traffic skills, vision or hearing supports, access to community/neighborhood, understanding of stranger, conflict resolution with others, and ability to use a cell phone or communicate from a community setting. Provide detail of activities currently engaged in and future desired activities..

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).

Family Involvement/Relationships:

This area should summarize relationships which support personal success. Describe family relationships (e.g., siblings, aunts, uncles, and extended family, etc.) Provide a summary of other supportive relationships (e.g., interpersonal relationships outside the family, former staff, teachers, and friends). Detail any guardian's restrictions due to safety issues, such as a legal restraining order. It should further identify those relationships which may pose an obstacle in gaining independence.

Communication Skills:

How does the individual choose to communicate? Include present, past and/or needed use of Assisted Technology, Augmentative Alternative Communication Devices. Identify communication assessments and therapies presently provided or in the past (e.g., preferences and choices on how the person communicates and with whom). 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.

Mobility:

Choices and desires associated with mobility issues (e.g., accessibility, space, transferring, and level of assistance). Adaptive equipment used for mobility should be specified here and in the Adaptive Equipment section. 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..



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Personal Care:

Summarize tasks which may be attempted and/or completed, as well as the level of support needed to complete certain tasks. Identify risk factors. Risk factors could include but are not limited to adjusting water temperatures, access to cleaning/hygiene supplies, noncompliance to tasks, and lifestyle choices that negatively affect health.

For further detail, assessments and reports may be attached.

Meal Time Assistance:

Summarize the level of supports needed at meal times. Is staff needed to assist with monitoring food intake during meals? Personal preferences and identified risk factors should be documented. Consideration should be given for "Use of the Kitchen" (stove, refrigerator, silverware, cooking implements, dishes, food items, adjusting hot & cold water, dishwasher, microwave, coffee maker, toaster, and other appliances). 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.

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.

Personal Decision Making:

Summarize situations the individual does make and situations when personal decision-making can be maximized (e.g., money skills, banking, ability to make purchases, scheduling, community access, giving direction, following direction, time management, attention to task, participation, religion, and leisure activities). 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.

Adaptive Equipment / Protective Equipment:

Summarize equipment or resources which increase independence or maintain safety (e.g., hearing aids, glasses, helmet, lift, plate guard, AFO, language device, specialized chair). 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. Risk factors could include but are not limited to potential choking or strangulation hazards, two-person assist, sensory loss, skin breakdown, heat caution, fall precaution, and re-positioning.

For further detail, assessments and reports may be attached.

Behavior Supports:

Summarize behavior and needed supports. Identify behavior modification techniques which may be effective. Include summary of behavior, frequency, severity, antecedents, duration, successful interventions and last episode. This section should include information regarding mental health needs and history of psychiatric admissions. Risk factors could include but are not limited to identifying techniques which are not effective, potential risk to self or others, isolation, refusal of services, elopement, substance abuse, inappropriate sexual behaviors, and law enforcement involvement.

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

Medical / Physical Well - Being:

Summarize 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.



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Medications:

Describe ability to self-medicate. What level of assistance is currently being provided to take medication(s)?

Risk factors could include but are not limited to medication side effects, allergies to medications, ineffective/harmful medical interventions. It is extremely helpful to providers to include a summary list of medications.

Legal Issues:

Summarize court/police involvement, trust fund Issues, guardianship, consents.

Other Risk Issues Not Identified or Human Rights Restrictions:

Summarize events or actions which may lead to certain consequences (e.g., community access, history of traumatic events, and 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) which may interfere with a person's ability to engage or interact appropriately.

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

Summary:

Summary of Past Transition and/or Supports:

Summarize individual history as it relates to past transitions (e.g., residential and service supports). This section may also contain a documented social history.

Support Needs and Time Table for Transition:

Summarize supports/activities needed to transition (e.g., overnight visit, day visit, dinner visit, staff familiarization, and an adjustment period). Develop a chronological schedule and process to summarize the transition.

Transition to new ISC Agency:

This section should be completed by the Current ISC agency when the individual is moving to a new geographical location, transfers to another service, or the Individual chooses to receive services from a new ISC agency. A summary should be provided which indicates the date planned for the new ISC to assume responsibilities. The current ISC is responsible for documenting the dates in which the new ISC agency was notified of this assumed responsibility.

Participation:

The ISC will record the date in which they met with the individual. The ISC should ensure that the individual's participation is clearly described.

The ISC will record the date in which they met with the guardian, if applicable.

People who participated in the *Ligas* Transition Service Plan:

The ISC agent will ensure that all people who participated in the development of the *Ligas* Transition Service Plan have been identified by name and title/relationship. Multiple meetings/contacts may be needed to complete the *Ligas* Transition Service Plan process. *Ligas* Compliance Standards require the participation of the individual and guardian in the *Ligas* Transition Service Plan. Family, friends, current staff, and those deemed important in the individuals life should be considered as potential participants.

Approval of the Transition Service Plan:

Upon Completion of the LTSP, the ISC will ensure the plan has been reviewed and approved by the individual, guardian (if applicable), and ISC. It may be necessary for the ISC to make revisions to the LTSP before approval of the plan. The ISC should ensure that referrals for services include the LTSP. The ISC should ensure that those individuals identified in the instructions have received a copy of the LTSP.