NORTH Dakota | Human Services
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DATE: April 8, 2022

TO: Daniel Gulya, Staff
ND Olmstead Commission

FROM: Heather C. Jenkins, Superintendent
Life Skills Transition Center, ND Department of Human Services

CC: Chris Jones, Director
ND Department of Human Services

RE: Request for Contextual Information

Thank you again for your invitation to make a presentation to the Olmstead Commission on April 20. I am looking forward to the opportunity to talk about the work of transition and diversion, particularly as it involves the Life Skills Transition Center (LSTC). I will be joined by Tina Bay, Director of the DHS Developmental Disabilities Division, and Jessica Thomasson, DHS Executive Policy Director.

We will be prepared to share information about the work that is underway to accelerate the pace of transition and diversion from LSTC, and also to share information about some of the challenges that continue to characterize the everyday realities of this work in our state.

In response to your specific request for policies and procedures as written contextual information for the Commission members prior to the April 20 meeting, I am attaching the following documents. Please know they are being shared as they exist today. We are in the process of refining a document that outlines "expectations" for guardians and team members as it relates to any admission to LSTC and would be happy to share more detail about that work when we talk later in April.

Referral to LSTC
Policy II-4: Accessing State Level Services: ND DHS Life Skills and Transition Center

Admission to LSTC
Procedure II-4a: Admission Team Review Procedure

Transition and Discharge
Procedure II-4c: Person-Centered Transition Planning for discharge of LSTC people served

Diversion
Policy II-5: Clinical Assistance, Resources and Evaluation Services (CARES) program

Procedure II-6d: CARES Crisis Coordinator (CCC) Transition Support from LSTC to the home, work, schools of person's choice

Policy Number: II-4

Title:	Accessing State Level Services: ND DHS Life Skills and Transition Center				
Date Created:	08/2009	**Version:**	N/A	**Date Approved:**	
Effective Date:					

Overview:

Purpose: The philosophy of the Department of Human Services is that supports are best provided closest to the person's home community. Accessing residential services of the North Dakota Life Skills and Transition Center (LSTC) or State Hospital (NDSH) for people with intellectual disabilities is required to be the last service option after all others are exhausted. Admission to residence, transfer, and discharge from state level service for people with intellectual disabilities may only be accomplished using the procedures of the Department of Human Services through supports of the local Human Service Center/Developmental Disabilities Program Management.

Definitions/Authority Reference:

North Dakota Century Code (NDCC) 25-04

Policy Statement:

Human Service Centers

- **Eligibility** for developmental disabilities, or specifically intellectual disabilities, services and screening to determine appropriate types of services are completed by Developmental Disabilities Program Managers (DDPM) at the regional level.
    - This is reviewed annually for all people in Developmental Disabilities services including those residing in state level services (LSTC or NDSH).
    - Each person Eligible for Developmental Disabilities Services has a DDPM to coordinate service and ensure quality of those services as per NDCC 25-04-04.1.
- A person for whom appropriate services cannot be provided in their preferred community may need to access services in another community.
    - If appropriate services are not available within the assigned (home) human service region, referral is made to all other regions (statewide) and alternative service provider alternatives exhausted.
    - For Acute Mental Health Services: Lake Region and South Central Human Service Centers have mental health crisis authority for direct admission to NDSH through evaluation by the Regional Intervention Services Coordinator (RIS). Such admission must have discharge plans to return to the region or else must follow the state level service procedures.
- The Director of Social Services at the LSTC is included in the process of statewide regional referral that is used to determine the availability of appropriate services and document the exhaustion of less restrictive alternatives.

- Less restrictive alternatives MUST INCLUDE referral to the LSTC Clinical Assistance, Resources and Evaluation Services (CARES) in a timely and cooperative manner designed to extend in-home or in-community alternatives.

- Licensure requires that in the case of involuntary discharge from a provider, a Person-Centered Support Plan Team meeting must be convened to discuss the reason for terminating services and the individual/legal decision-maker must be given a 30 day written advance notice prior to the discharge. There is an emergency clause that may allow a provider to cease supports immediately under extenuating circumstances. The person/legal decision maker must be advised of their right to appeal through the provider's internal grievance policy.

Admission to the LSTC by Transfer between NDSH and LSTC

1. Referral to the LSTC is only after all appropriate statewide options are exhausted. Application materials to LSTC must include:
    - Signed application for admission by the legal decision-maker
    - Court-related information clarifying legal decision-making capacity and obligations (e.g. guardianship, probation/parole orders, custody orders, etc.).
    - Progress Assessment Review (PAR) screening assessment.
    - Risk Management Assessment and Plan (RMAP).
    - Fully completed Therap Individual Data Form (IDF)
    - Most Recent psychological evaluation containing
        i. intellectual assessment information AND
        ii. adaptive assessment information,
    - Current physical examination report and prescriptions (including orders),
    - Current planning documents (e.g. IEP, support plan, methods of behavior health support),
2. The Department of Human Services (DHS) administration determines admission to the LSTC or NDSH facilities based upon the most appropriate services to meet the person's needs and the service setting capacity.
    - The maximum capacity at the LSTC is determined by the Superintendent of the Life Skills and Transition Center. This capacity may include program limits that cannot be changed through the general capacity. The LSTC is available for admission from any region within the limits of such capacity.
3. The DDPM completes the Individual Service Plan (ISP) in Therap upon admission to the LSTC/NDSH.
4. A Support Plan is conducted within 30 days of admission to LSTC with team members from all pertinent aspects of the person's life (e.g. family, friends, previous provider, DD Program Manager, etc.).
5. The Department of Human Services (DHS) administration determines transfer, if necessary, between NDSH and LSTC in consultation with legal decision makers and the involved DD Program Management staff. Such transfer is upon a clinical determination of the most appropriate service setting between the two facilities by the Department of Human Services Administration.

In Residence

- Developmental Disability Program Management completes the Screening for ICF/ID-HCBS Eligibility prior to admission and annually thereafter.
    - DDPM completes Screening prior to each annual Person-Centered Support Plan

    - DDPM maintains the case as open while residing at LSTC/SH.

LSTC members scale is 1-3

- The residential Decision Profile (RDP) scores are completed at the Support Plan to aid the team in determining consensus of supports needed for transition to the person's preferred community. The RDP includes key team members, especially the DD Program Manager scoring on a five-point scale (1-5). Scoring:
    - 1 reflects that the services needed are available (not dependent upon opening) in the regions of interest,
    - 2 reflects that the services appear to be available with some reservations in the regions of interest,
    - 3 reflects uncertainty about the appropriate services being available in the regions of interest,
    - 4 reflects that the appropriate services do not appear to be available with reservations that suggests further investigation may be useful in the regions of interest, and
    - 5 reflects that the appropriate services to meet the person's needs do not appear to be available in the region(s) of interest.
- The LSTC Person Centered Support Plan incorporates the Risk Management Assessment and Plan (RMAP) for transition planning for discharge.
- The DDPM provides completed PAR summaries to the Quality Support Services (QSS) Department of LSTC to maintain on file as ICF/IID certification.
- Admission Type is determined to be:
    - **Regular Admission Service:** People are considered eligible for admission without regard to age, religion, ethnic origin, sex or ability to pay. Only individuals determined to be eligible for developmental disabilities services by the Department of Human Services and declined service by all private provider-based programs will be considered eligible for admission to the Center.
    - **Evaluation Service:** This is the equivalent status as **Regular Admission Services** but is limited in time for a specific service. Under rare circumstances a person is admitted to the Center under Evaluation service, such as when ordered by the Courts for an evaluation or for a specialized assessment or service. In most instances, other residential services may be arranged during the evaluation period to avoid the need for residential admission.
    - **Respite Service:** Respite Service is required by North Dakota Century Code to be provided to people younger than 22 years old at the Center when community respite services are not available or not adequate to meet the person's needs. All initial admissions to the Respite Service must be approved by the Superintendent. This decision is based upon the appropriateness of the request and space available at the Center. The respite period cannot exceed 29 days. Respite Service is not usually available to consumers of Private DD Providers. If an individual is thought to need time away from a private provider, it is likely due to maladaptive behaviors, medical needs, or other similar issues. In these situations, given the likely provision of intense services to the person experiencing difficulties, referral for CARES consultation would be more appropriate.

Discharge

- The Developmental Disabilities Regional Program Administrators (DDPA)

work within the team on specific discharge plans with regional providers and other regions as necessary.
    - Authorizations to Disclose Information (ADI) are obtained by the LSTC Social Services and DDPM/PA for person asking for such referral.
        - The ADI is to exchange information with all providers in their assigned region and other regions (and associated providers) specified by the person/legal decision-maker.
        - Information is placed where the DDPA and DDPM may access it for use in the Therap Referral System.
        - A Transition Plan is completed with the Support Plan to monitor referral progress.
    - Private providers review each person on the Therap Referral System and may offer services through that mechanism.
    - DDPA/DDPM contact LSTC Social Services and PC of any private provider offering services to work out further details.
- Transition planning shifts to working out specific details upon acceptance and establishment of a tentative date for admission to another provider or the family's home.

Forms that apply:

Appendix:

SUPERINTENDENT **DATE**

History of Policy:
11/17; 11/19

Procedure Number: II-4a

Title:	Admission Team Review Procedure				
Date Created:	2002	**Version:**	N/A	**Date Approved:**	
Effective Date:	12/1/2019				

Overview:

Purpose:

Provide stepwise procedures for the necessary implementation of restrictive supports and technology to ensure the safety of people served and the community of people with whom they live.

Definitions/Policy Reference:

Policy on Accessing State Level Services

Procedure:

An Admission Team Review is held on the day of arrival of a person beginning to receive residential services, whether in Intermediate Care Facility (ICF) or Resident Habilitation (ResHab) service settings. The Admission Team Review ensures that necessary information is exchanged to provide guidance for the first 30 days of service. The sequence of events at the Admission Team Review are:

I. Introductions, people present sign attendance form, team members check-off
   a. Minutes format collects the information below

II. Review Reason for Admission and related legal issues:
   a. Admission Type:
      i. Voluntary-by self
      ii. Voluntary by other
      iii. Involuntary court order/commitment
      iv. documentation goes into THERAP
   b. If court involved, name court & dates (hearings, end dates, etc.)
      i. Make clear in minutes
   c. Guardians' authority for Voluntary Admission terminates in 45 days
      i. Identify the date
      ii. Clarify next steps to continue the authority (45 Day petition)
   d. If guardianship, limitations review
      i. enter in Rights Restoration document
      ii. guardianship document to be stored Therap Document Storage
   e. **Reason to remain beyond 45 days for guardian report, if appropriate**
      i. **Statement in the minutes to be used in the 45 day petition and reviewed at the Support Plan annually** entered into the minutes of the Admission Team Review

III. Admission Status: for recording in THERAP and Avatar software systems
   a. Identify TYPE of ADMISSION and review conditions as appropriate

i. Review RESPITE conditions (less than 30 days, support services only, etc.)
ii. Review FULL ADMISSION:
1. Evaluations are due prior to Support Plan
2. Existing Overall Support Plan status to be adopted for the first 30 days

b. Review REPRESENTATIVE PAYEE, Reason to not change
i. There is no good reason NOT to change the PAYEE to the LSTC, but clearly not a requirement. Business office will work with people if chose not to.
ii. Document reason (e.g., preference of guardian) to NOT change Payee.
iii. Be sure to add decision in Rights Restoration if LSTC becomes the Rep Payee

c. Identify STAFF assigned to PERSONAL PROPERTY & SAFETY DRILL – in MINUTES
i. Staff person doing inventory is IDENTIFIED in the Minutes
ii. Safety Drill staff person responsible is IDENTIED in the Minutes
iii. REMINDER to Program Coordinator and residential staff present that a T-Log must be completed with topic **In Subject** line done for each, Inventory and Drill!!

d. Identify MONEY TO DEPOSIT documented in Minutes
i. Identify STAFF RECEIVING DEPOSIT by name
ii. Identify MONEY HELD by the person in the MINUTES

e. Legal Decision-maker Preference of methods of contact for Restrictions and Medications
i. Document in the minutes how the decision-maker would prefer to be contacted

f. Take PICTURE for THERAP documentation
i. note Height, Weight, Hair & Eye Color for entry into Therap record

g. DISCHARGE PLAN: Re-submit in Therap Referral
i. Whether Statewide
ii. Selective Regions
iii. Include/Exclude Providers

IV. SP Schedule Date: 30 days in MINUTES with reference to Support Plan Schedule
a. SP date set with time and place
b. Offer Conference calling with DD Program Manager and other non-local team members
c. ADMISSION MEETING ATTENDANCE FORM requires initial Team Member Check-off
d. Review implementation of existing SP and Methods of Positive Support in minutes

V. Relationships:
a. Contacts in previous living situation identified in MINUTES and how this will be stored (address book, memory book, etc.)
b. Agency contacts from previous services/relationships and how to maintain contact
c. Friends/family contacts (natural supports) and how their information will be stored. Any limitations to contacts or additional supports needed for specific people.

VI. RIGHTS Review
a. Give RIGHTS RESTORATION Approval Forms (acknowledging providers' approvals)
i. Human Rights Committee from previous services
ii. Peer Review Committee from previous services
iii. LSTC Rights Restoration Form acknowledged

b. Review Limits of Rights
i. Line of Sight, Freedom of Movement, Socialization, Medication in minutes

c. Establish restrictiveness areas and plans for Rights Restoration
    i. TO BE submitted to HRC immediately
d. Review Advocacy contacts – P&A, Ombudsman, guardian, attorney, etc. in minutes

VII. Authorizations
a. Authorization for Medical Services – Forms completed
b. Authorization to Disclose Information – Forms completed
    i. To be stored in THERAP: AUTHORIZATION & CONSENT
c. Authorization for Services (includes MPS) by Legal Decision-maker approval
    i. Form THERAP: AUTHORIZATION & CONSENT
d. E-Mail or Phone calls preferences
e. Choice in Professional Services Review:
f. Note that LSTC Professionals will be assigned initially
g. By the Support Plan
    i. please chose preferred service providers from those in the area
    ii. we can help you find local services if you prefer, we cannot pay for it or give out of town transportation in most situations

VIII. Further Notes: described in the minutes
a. Background,
b. Skills,
c. Routines, and
d. Adjustment information

Forms that apply:
Admission Team Review Form
Admission Team Review Signature Form

Appendix:

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SUPERINTENDENT **DATE**

History of Procedure:
11/15; 11/19; 02/22

Procedure Number: II- 4c.

Title:	Person Centered Transition Planning for discharge of LSTC people served				
Date Created:	5/7/2020	**Version:**	N/A	**Date Approved:**	
Effective Date:	5/7/2020				

Overview:

Purpose: The Person-Centered Transition Plan (PCTP) is a product of the Transition Task force, consisting of members working in the IDD field, across DHS, including private ID support agencies. The PCTP will be utilized for all individuals receiving services at LSTC. The document outlines all details involved in a person's transition and tracks provider interests in, and activities with, individuals. We will also use the PCTP to document LSTC & Provider duties/responsibilities/activities during transition. It is our purpose to teach and train the new provider staff.

Definitions/Policy Reference: PCTP=Person Centered Transition Plan

Procedure:

General instructions

Supporting teaching and training versus lead staff

Checklist of awareness of duties/tasks during transition move or visit

(ie-List examples of examples of what is appropriate and what is not)

How:

- All provider related discussions should be directed to the SW Dept. The SW Dept. requires invitations to TR's regarding transition discussions. If providers or DDPMs contact any member of the team directly, they should refer the provider/DDPM back to the SW Dept. or schedule a meeting involving the SW. Dept.

- The Transition Document will be reviewed and updated as providers express interest, make visits, decisions, etc. Team Reviews regarding D/C will be scanned to SWK dept for inclusion with PCTP. The PCTP is meant to be a fluid document maintained over time on all activities and events related to transition planning for that person.

- Included in the PCTP will be specific activities and actions meant to aid the person in a smooth move from LSTC to a private agency. These supports are discussed in team reviews with the provider including the plan for LSTC hands-on support during move, periodic check in's, and follow-up plans. (It is very important that this discussion is thoroughly documented in the team review minutes.) Once team has developed the criteria, it will be outlined in the transitions document and team review minutes and sent to Residential Unit Director for approval. The Residential Unit Director and/or Superintendent must approve this outlined criterion prior to the person being transitioned to their home in the community.

- When an individual is not chosen, this information needs to be included in the PCTP for tracking purposes. Or, if there was interest, but a provider later reneged, needs to be documented as well.

The Social Work Department will need notifications of the following:

Team Review:

Any time providers interact with LSTC about discharge, including decisions on making a referral, this should also be documented in the meeting minutes.

ADI with transition agreement:

When new ADIs are signed, or guardian agrees to the referral. If you have knowledge of this, the SW Dept should be notified. The ADI may come from the DDPM at times versus LSTC obtaining it. These will normally be handled by the Social Work Department.

511 Vocational Rehabilitation interviews:

Dakota East will have the Individual's 511 on record. SW Dept will remain aware, but if you are notified of the interviews, please keep SW dept up to date so we can include in PCTP.

Please alert the SW dept anytime referral documents are requested by providers or DDPMs. We understand, at times, later in the transition process, documents are shared with providers by PC. Just be sure you are notifying SW of the dates and specific documents shared.

Provider visits:

The SW Dept. will be involved, and likely, facilitating, when a provider visits an individual on LSTC grounds.

Guardian/family/person tours – Typically goes through DDPM for arrangements, but if you become aware, SW dept will need to know dates, provider, and who toured. SW dept will also notify Superintendent per her request, we have observers/visitors on campus.

Move date:

A date of the person's move is negotiated and set. If the date changes this needs to also be communicated.

Staff supports training of new staff:

The benefits of Provider staff coming to train at LSTC with the individual being admitted, needs to be weighed and efficacy decided. If it is felt this is necessary, LSTC will make recommendations.

When the PC trains the new provider on the OSP/MBS plans, we need to document. The dates vocational staff are trained, the dates home staff trained, need to be documented.

PC and resident Services will develop a Transition Plan of staff support. We will designate times and duties expected. We will also require some brief documentation by staff helping person transition. This document will be reviewed and signed by LSTC Superintendent and Provider Director or representative.

30-day meeting:

At the provider's admission meeting, PC needs to alert others, LSTC would be participating in the person's 30-day Intake Plan, per transition protocols. The PC will then schedule the 30-day meeting, much as you would a Team Review, including type of connection used (Skype/MS Teams).

6 month review:

The Program Coordinator will place a call 6 months post D/C, to inquire how person has adjusted. Any concerns, requests for assistance will be addressed. This will be documented as well.

Guiding Principles for Person-Centered Transition Planning:

The focal person drives the transition process.

- ***Listen carefully to the person, no matter the communication style. Honor the person's choices of what is needed and desired to be successful.***
- Base decision making on building a better and better understanding of the details that really matters to the person.
- Build on the person's capacities, including interests and skills, and support achievable goals that build success.

Involve the person's "support network" to create a collaborative transition process.

- Identify and involve people who knows the person well, who have positive relationships, and a long history such as family members, current and past providers, and friends.
- Identify the "key person" who will be involved throughout the person's transition and will help ensure the transition is successful.
- Build a "support network" that works well together which includes:
  - Clear and active communication and clarifying who does what;
  - Flexibility when making plans so everyone can show up (i.e. staff schedules, family's available time);
  - Information shared that is positive and useful, so the person's story is not lost when moving from one setting to another; and
  - Expertise shared between institutional and community staff, such as doctors, direct support staff.
- Involve families and address their concerns and the supports they may need for this transition, such as, reassurance, other families who can provide advice, or professional counseling.

Develop a transition process that's realistic and ensures success.

- Start transition planning as soon as possible.
- Provide helpful resources and enhancements while the person is still at the institutional setting and determine what and how those helpful supports can be translated to the community setting.
- Take as much time as needed for the move to be successful while taking into consideration the benefits of moving with what's necessary to be in place before making the move. There may be additional considerations when individuals are moving across the state or to a community they don't know.
- Balance attention to meeting assessed needs with actions that create new stories that grow from what becomes possible with the move.

Build community supports so the person can be an active member of the community and have positive relationships.

- Start to develop community supports, networks, relationships before the person leaves the institution that will enhance success including locating affordable housing in a safe neighborhood, working with local first responders and medical and mental health providers, identifying employment supports along with the appropriate county, developing relationships with neighbors, identifying social groups and activities available in the community.
- Continue to build on these community support networks and relationships once the person moves including maintaining old and establishing new non-paid reciprocal relationships with others (family, community members, and staff), securing employment and getting involved in social groups and community activities outside of home.

Forms that apply:

Person Centered Transition Plan (PCTP)
PCTP Supports Provided
PCTP Pre-schedule
Attach Team Reviews of Transition Discussion

Appendix:

SUPERINTENDENT **DATE**

History of Procedure: Transition Task Force est. 2005

Policy Number: II-5.

Title:	Clinical Assistance, Resources, and Evaluation Service (CARES) Program				
Date Created:	11/1/19	**Version:**	N/A	**Date Approved:**	
Effective Date:					

Overview:

Purpose:

The CARES Program serves to support people with developmental disabilities to remain in their home community or transition to another community of their choice through effective and efficient use of expertise and experience of the Life Skills and Transition Center (LSTC). The clinical and experience specialty resources of the LSTC, always in collaboration with local support services, facilitates use of the full continuum of services and supports with which to wrap around the person and their support network.

Definitions/Authority Reference:

ND Century Code 25-04

Policy Statement:

The CARES Program works in coordination with all other human service resources with the goal of supporting the person to remain in their home community or move to a community of their choice. This coordination is accomplished through the CARES Team process in collaboration with the local support services of the person, generally centered around Developmental Disabilities Program Management.

The LSTC's resources are available to those eligible for developmental disability services in North Dakota, including applicable early intervention. The CARES Program is the aspect of services reserved for people not currently served residentially by the LSTC. Reimbursement for services are expected to be generated through appropriate sources as applicable.

CARES support may include a wide range of resources in amount and intensity along a continuum of consultation modalities from all aspects of the agency. The LSTC has developed specializations in developmental disabilities in an extensive array of disciplines (behavioral health, occupational and physical therapy, nursing, etc.), service roles (program coordination, direct support professionals, etc.), and technologies (adaptive equipment, communication alternatives, data analysis, etc.).

CARES Program component parts include:

- CARES Operations: Director of Social Services as the referral point
- CARES Team: clinicians and staff coordinating referrals and services
- CARES Staff: direct support staff schedulable for on-site services
- CARES Clinic: discipline staff available for clinic billable services of assessment and treatment
- Developmental Disabilities Behavioral Health Service (DD BHS): applied behavior analysts doing billable clinical consultation services
- CARES Crisis Assistance Program (CAP): using a variety of agency resources that may include onsite or telephonic coaching supports, to out-of-home supports with local, regional or state level hospital or crisis residential options. This includes all referral support to the Department of Human Services Behavioral Health Crisis Service.

Onsite observation and coaching support are assistive and does not involve direct responsibility for the care of the person unless otherwise admitted to an LSTC residential or day service. Support of other care providers is at their direction and management, and under their responsibility.

Services may range from direct assessment, to recommendations of methods through to coaching direct support staff and professionals on support implementation.

Forms that apply:
CARES Program Application

Appendix:

SUPERINTENDENT **DATE**

History of Policy:
11/2019; 02/22

Procedure Number: II-6d

Title:	CARES Crisis Coordinator (CCC) Transition Support from LSTC to the home, work, schools of persons choice				
Date Created:	09/2020	**Version:**		**Date Approved:**	
Effective Date:					

Overview: CCC support in the transition of people moving from the LSTC/NDSH or agencies to homes across the state.

Purpose: To support and ensure the successful transition of people moving from the LSTC to homes in the community of their choice.

Definitions/Authority Reference:

CARES Crisis Coordinators (CCC): Provides prevention and intervention services to people with Intellectual Disabilities/Developmental Disabilities and Behavioral Health needs with crisis response, training, and consultation. These services are available 24/7 through the CARES Crisis Coordinators.

Developmental Disabilities Program Manager (DDPM): has primary responsibility to provide assistance and support to people with intellectual or developmental disabilities through coordination and monitoring of services.

Life Skills Transition Center (LSTC): A state-operated, comprehensive support agency for people with intellectual and developmental disabilities, with administrative offices and residential and day services located in Grafton, N.D. The center provides specialized services and is a safety net for people whose needs exceed community resources.

CARES Team: Clinicians, direct support staff and other staff coordinating referrals and services throughout North Dakota.

CARES Program: Clinical Assistance, Resources and Evaluation Services for people with Intellectual / Developmental Disabilities throughout the state of North Dakota. Services include but not limited to in-home remote Crisis support services (Behavioral Health Team with CARES Specialist), in-home technical assistance, training for community professionals/Direct Support Professionals/Families/Law Enforcement/other emergency responders, provided assessment/observation services remotely in person's home. Crisis beds at the LSTC for short term admissions and stabilization.

Person Served: Any citizen in North Dakota who is eligible to receive Developmental Disability Services.

Procedure:

1. The CCC will be included in transition planning meetings.
2. The CCC/ABA in conjunction with the CARES program manager, will act as the coordinator of the CARES Team for the person. This includes initiating internal meetings and coordinating CARES services.
3. All service data collected will be documented and shared with identified CARES Team members.
4. CCC services identified by the CARES Team will continue as long as necessary.

Forms that apply:
Person Centered Transition Plan

Appendix: N/A

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SUPERINTENDENT **DATE**

History of Procedure: **08-19-2021**