

HCBS/TBI Waiver Transition Plan

Consumer _____

Case Manager _____

Date _____

PLEASE DO NOT INCLUDE THE INDIVIDUAL'S NAME OR ANY IDENTIFYING INFORMATION IN YOUR COMMENTS (including your agency, names of providers, school's or facilities the individual attends, etc.). THIS FORM MAY BE GIVEN TO A COMMITTEE FOR REVIEW AND THE INFORMATION MUST BE CONFIDENTIAL AND BIAS FREE. THE INFORMATION GIVEN ABOVE AND THE SIGNATURE WILL BE REMOVED PRIOR TO DISEMPOWERMENT OF THE FORM TO THE ADMINISTRATIVE REVIEW TEAM.

Section I. Transitional Living Skills

- 1) Please list the measurable skills/goals the individual wishes to acquire while on the TBI Waiver and the associated time frame for achieving them.

Goal

Expected Date of Achievement

- 2) Which of these measurable skills/goals does the person hope to accomplish in the next year?

- 3) What additional, measurable skills/goals are essential for the person to successfully transition off the TBI Waiver?

