ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Planning Document



# RESIDENTIAL PRE-MOVE CHECKLIST

**Support Coordination must complete this form for members who are moving into or between DDD residential settings.**

Member's Name *(Last, First, M.I.)*: _____ Date: _____

Support Coordinator Name: _____

Guardian/Responsible Party: _____

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**Move**

From: _____

To: _____

Target Date for the Move: _____ Time of Pick Up: _____

Reason for Move: _____

Current Qualified Vendor present, if not please explain: _____

Future Qualified Vendor: _____

Current Employment/Day Program Vendor present, if not please explain: _____

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*The following forms must be available at the pre move meeting:*

- Spending Plan DDD-0221A
- Safeguards in Licensed Residential Settings DDD-1569A
- Residency Agreement DDD-2176A

1. Please describe the day of the move, including who is assisting with transport/packing/unpacking including moving arrangements. How will the member and the family/guardian be involved in the move?

   _____

   Document discussion and action items:

   _____

2. Does the member have their own furniture, or will the new vendor need to provide it?

   _____

   Document discussion and action items:

   _____

3. Has an inventory (clothing/personal property) been created and/or shared with the new vendor and the member/guardian? ☐ Yes ☐ No ☐ N/A (not applicable if in family home)

   Document discussion and action items:

   _____

4. Have the vital records (e.g., birth certificates, social security card, guardian documents, court documents, etc.) been shared with the new vendor and/or the member/guardian? ☐ Yes ☐ No ☐ N/A

   Document discussion and action items:

   _____

See page 6 for EOE/ADA disclosures

5. Will the move require a change in the Primary Care Physician (PCP)? ☐ Yes ☐ No

   If yes, person responsible: _____

   If no, person responsible for notifying PCP of move: _____

   Document discussion and action items:

   _____

6. Will the move require a change in the Behavioral Health Provider? ☐ Yes ☐ No ☐ N/A

   If yes, person responsible: _____

   If no change required, person responsible for notifying Behavioral Health Provider Agency of move:

   _____

   Current BH Provider Agency/Contact: _____

   New BH Provider Agency/Contact if applicable: _____

   Document discussion and action items:

   _____

7. If the member has a Crisis Plan, has it been updated and shared with the vendor? ☐ Yes ☐ No ☐ N/A

   If no, please describe: _____

8. Does the member require a Behavior Plan (as outlined in Article 9)? ☐ Yes ☐ No ☐ N/A

   If there is a current plan approved by DDD/PRC (Program Review Committee), has it been shared with the new agency including all materials needed to implement the plan? ☐ Yes ☐ No ☐ N/A

   Who is identified to provide orientation to staff on the existing Behavior Plan?

   _____

   If a Behavior Plan needs to be developed, person responsible for creating the new Behavior Plan (within 90 days) in the Person-Centered Service Plan (PCSP): _____

   Document discussion and action items:

   _____

9. If the member has skilled nursing needs, has the Healthcare Services District Nurse been notified of the move, and have hourly nursing visits been arranged? ☐ Yes ☐ No ☐ N/A

   If no, person responsible for notifying the Healthcare Services District Nurse: _____

   Document discussion and action items:

   _____

10. Has durable medical equipment been identified, ordered, and arranged by the Health Plan prior to the move (e.g., Augmentative Device, wheelchair, shower chair, handrails, Hoyer lift or elevated toilet seat, etc.)?
    ☐ Yes ☐ No ☐ N/A

    If no, person responsible: _____

    Document discussion and action items:

    _____

11. Has the Medical Equipment/Supplies Provider been notified of the move (e.g., nutritional supplements, diabetic supplies, incontinence supplies, etc.)? ☐ Yes ☐ No ☐ N/A

    If no, person responsible: _____

    Document discussion and action items:

    _____

12. Does the member have a G-tube, colostomy, or any other non-skilled medical needs? ☐ Yes ☐ No
    If yes, has the new vendor been trained or scheduled for training prior to the member moving in?
    ☐ Yes ☐ No ☐ N/A
    Document discussion and action items:

13. Will the move require a change in Pharmacy? Include current pharmacy information. ☐ Yes ☐ No ☐ N/A
    Current Pharmacy/Crossroads/Location:

    New Pharmacy/Crossroads/Location if applicable:

    If yes, person responsible: _____
    Document discussion and action items:

14. Does the member have an adequate supply of medications and current prescriptions? ☐ Yes ☐ No ☐ N/A
    If no, person responsible: _____
    Document discussion and action items to prevent a lapse in medication:

15. Will the move require a change in Employment Services or Day Program? ☐ Yes ☐ No ☐ N/A
    If yes, person responsible (should not be the qualified vendor for DDD funded programs):

    If no, person responsible for notifying Employment or Day Program of move: _____
    Current Employment/Day Program and Contact Name/Phone:

    New Employment/Day Program and Contact Name/Phone if applicable:

    Document discussion and action items:

16. Will the move require a change in School/District? ☐ Yes ☐ No ☐ N/A
    If yes, person responsible: _____
    If no, person responsible for notifying School/District of move: _____
    Current School and Contact Name/Phone: _____
    New School and Contact Name/Phone if applicable: _____
    Document discussion and action items:

17. Are there any community activities that the member would like to continue to do after the move (ex. church, special olympics, dances, etc.)? ☐ Yes ☐ No ☐ N/A
    Document discussion and action items:

18. Is the member assessed for therapy services? ☐ Yes ☐ No ☐ N/A

    If yes, person responsible for notification: _____

    Current Therapy Agency Contact Name/Phone: _____

    New Therapy Agency Contact Name/Phone if applicable: _____

    Document discussion and action items:

    _____

19. Will the residential setting or vehicle require modifications or additional equipment (e.g., grab bars, ramps, plexiglass or film on windows, etc.) in order to meet the member's needs? ☐ Yes ☐ No ☐ N/A

    If yes, person responsible: _____

    Document discussion and action items:

    _____

20. Does the member have any power dependency needs? (i.e. ventilator, oxygen concentrator, electric wheelchair) ☐ Yes ☐ No ☐ N/A

    Document discussion and action items:

    _____

21. What Health Plan is the member enrolled with?

    Health Plan Name: _____

22. Has the Health Plan card been provided to the new provider? ☐ Yes ☐ No ☐ N/A

    Document discussion and action items:

    _____

23. Is there a Care Manager from the Health Plan assigned? ☐ Yes ☐ No

    If yes, Care Manager name and contact information: _____

    Document discussion and action items:

    _____

24. Has an Electronic Member Change Report (EMCR) for the move been completed? (LTC only) ☐ Yes ☐ No ☐ N/A

    If yes, date EMCR was completed: _____

    If no, document discussion and action items:

    _____

25. Who is the payee?

    Payee Name/Contact Information: _____

    If Client Funds is the payee, have they been notified by the Support Coordinator of the move? ☐ Yes ☐ No ☐ N/A

    If there is a different payee, has the payee notified Social Security of the move? ☐ Yes ☐ No ☐ N/A

    Person responsible: _____

26. Does the member have personal funds at the current home? ☐ Yes ☐ No ☐ N/A

    If yes, person responsible for returning it to the payee: _____

    Document discussion and action items:

    _____

27. Has the Spending Plan form DDD-0221A FORFF been created/updated? ☐ Yes ☐ No

    Document discussion and action items:

    _____

28. Has the Safeguards in Licensed Residential Settings form DDD-1569A FORFF been created/updated? ☐ Yes ☐ No

    Document discussion and action items:

    _____

29. Has the Residency Agreement been completed? ☐ Yes ☐ No

    If no, must complete prior to moving, and indicate the plan and person responsible:

    _____

    Document discussion and action items:

    _____

30. Has the member visited the new home? ☐ Yes ☐ No

    If no, person responsible for coordinating the visit: _____

    Document discussion and action items:

    _____

31. Has the 10 or 30 day post-move meeting been scheduled as required in the Division's Medical Policy Manual Chapter 1620 - Service Plan Monitoring and Reassessment Standards? ☐ Yes ☐ No

    If no, person responsible: _____

    Document discussion and action items:

    _____

32. Have services been authorized to the correct site in the Focus/Member Case Management Application, and has the address book been updated? ☐ Yes ☐ No

    If no, person responsible: _____

    Document discussion and action items:

    _____

33. Will any current direct care staff be following the member to the new home? ☐ Yes ☐ No ☐ N/A

    How will the new direct care staff be oriented and trained to meet the member's needs?

    _____

34. Is the member on a special diet? ☐ Yes ☐ No

    If yes, document discussion and action items:

    _____

35. Will the member require any enhanced staffing support needs, and has this been documented on the Person-Centered Service Plan? ☐ Yes ☐ No ☐ N/A

    If yes, describe what this will look like (i.e. arms reach or eyesight, awake hours only):

    _____

    If no, person responsible: _____

    Document discussion and action items:

    _____

36. Is the member a registered voter? ☐ Yes ☐ No ☐ N/A

If yes, has voter registration been notified of the move? ☐ Yes ☐ No

Document discussion and action items:

_____

37. Has Network been notified of the move-in date? ☐ Yes ☐ No

If no, person responsible: _____

Document discussion and action items:

_____

CC:

Onbase Member File, Section S4.5 Placement Profile