Oregon
Theodore R. Kulongoski, Governor

Department of Human Services
State Operated Community Program Office
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DATE: 04/01/2010

TO: Program Managers, Site Managers

FROM: Laura Traeger, Program Administrator
State Operated Community Program

SUBJECT: 3.002 Internal Client Moves Guideline – and related forms

The SOCP 2.003 Exit/Transfer – "Internal Client Moves Guidelines" have been updated and posted to the SOCP Guidelines web page. Updates include:

- Environmental changes required before move
- Submission of "Work Order" to SOCP Director with detailed information
- Considerations to provide for a positive transition for staff/client(s)

Forms that apply

DHS 4632 Needs Meeting
DHS 4625 Relocation Plan
DHS 4622 Referral Packet Checklist
DHS 4612 Work Order Word PDF
DHS 4613 Health List

c: Program Managers
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SOCP Needs Meeting Form

Name	Meeting date	Date/time for entry/exit/transfer meeting

Moving ***from*** house name/program:

House name, agency or program

Address: *City, State, Zip*

Date of actual move *Time*

Transportation provided by:

Moving ***to*** new house name/program:

House name, agency or program

Address: *City, State, Zip*

Date of actual move *Time*

Medical supports

Describe medical supports: *Type of health plan, meds, treatments, OT/PT, nutrition, risks, protocols, vision/hearing etc:*

Environmental changes needed:

LIST:	DHS 4612 Work order ☐	Completion date:	Completed	Date
	Yes ☐ No ☐			
	Yes ☐ No ☐			
	Yes ☐ No ☐			
	Yes ☐ No ☐			

List current medications	Given for	List current medications	Given for

Current pharmacy: _____ Cycle fill date: _____

List of known communicable diseases:

Adverse drug reactions/allergies:

Major illness/hospitalizations:

Support needs

Behavioral supports/psychiatric diagnosis or history:

Staffing needs:

Family/guardian involvement:

Transportation needs:

Equipment/personal belongings:

Financial information:

Vocational/Day/Educational plan:

Any physical limitations that could affect work/day program?

Personal cares needs:

Communication:

Transition planning		Staff training		
Date/time	Shift	Date/time	Trainer	Item to be trained

Signatures			
Signature of meeting participants	Relationship to supported person	Date	(✓) Agree - needs can be met

Signatures			
Signature of meeting participants	Relationship to supported person	Date	(✓) Agree - needs can be met

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SOCP Relocation Plan

- ☐ Admission/Entry
- ☐ Transfer outside of county
- ☐ Transfer within county
- ☐ Exit to private provider

Name: _____ DHS prime no: _____ Meeting date: _____

Target date for move: _____ DOB: _____ Age: _____ Gender: _____

Reason for move: _____

Alternatives considered: _____

Contact information:

Previous placement: _____ Address: _____ City: _____ State: _____ Zip: _____

Current service coordinator: _____ Phone: _____ FAX: _____

Address, State, Zip code: _____

Receiving service coordinator: _____ Phone: _____ FAX: _____

Address, State, Zip code: _____

Guardian: _____ Phone: _____ FAX: _____

Address, State, Zip code: _____

Family: _____ Phone: _____ FAX: _____

Address, State, Zip code: _____

Representatives contact information:

Health care rep.: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Religious preference: _____

Professional services:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Optometrist: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Most recent and upcoming examinations:

Type of exam	Last exam	Next exam	Type of exam	Last exam	Next exam	Type of exam	Last exam	Next exam
Physical:			Vision:			Neurology:		
Lab work:			Pap:			Mammogram:		
Psychiatrist:			Dental:			Other:		
Other:			Other:			Other:		

Financial information:

Bank:		☐ Checking account no:		☐ Savings account no:	
		Current balance:		Current balance:	

Income/benefits: ☐ SSI: ☐ SSB: ☐ Other:

Does this person pay a service contribution? Amount: DAC: ☐ Yes ☐ No

Rep payee:

DSO/Medicaid office:

Who will notify DSO of move:

Burial plan:

Notes:

Name: _____ DHS prime #: _____ Meeting date: _____

List all current medications/treatments:

Current medications	Given for	Dosage	When given

List all current medications/treatments ☐ **Self administered medications**

Current medications	Given for	Dosage	When given

Current pharmacy: _____ Cycle fill: _____ Phone: _____

☐ This individual will have medications and/or treatments dispensed by more than 1 pharmacy until meds/treatments from previous pharmacy are exhausted.

Name: _____ DHS prime #: _____ Meeting date: _____

Assessment information:

Fire evacuation: _____

Street safety: _____

Water temperature: _____

Nursing Care Plan (NCP)/health list:

Health list ☐ Focused ☐ Limited ☐

Issue(s) for Limited NCP or Focused NCP: _____

Transition plan:

60 day ISP scheduled: _____ Location: _____

Notes: _____

Educational plan:

☐ Contact school district: _____ ☐ Former school district: _____

☐ School/Home tutor ☐ Schedule transfer to new school

Notes: _____

Location of documents:

Remains at current house		Transfers with the client to another SOCP home. *(Must be hand delivered and signed off by both managers.)*		Goes with client to private provider	
☐	Copy of BSP	☐	FTC black book	☐	FTC black book
☐	Copy of RTR	☐	ISP	☐	ISP
☐	Copy of financial records	☐	RTR	☐	RTR
☐	Copy of property records	☐	Financial records	☐	Protocols
☐	Copy of relocation plan	☐	Property record	☐	Safety plan

Name: _____ DHS prime #: _____ Meeting date: _____

Location of documents:

☐	Copy of needs meeting notes	☐	Protocols	☐	Financial plan
		☐	Safety plan	☐	FA/BSP
		☐	Financial plan	☐	Relocation plan
		☐	BSP/FA	☐	Needs meeting notes
		☐	Individual summary sheet		
		☐	Referral packet		
		☐	Relocation plan		
		☐	Residential book		
		☐	Needs meeting notes		

Entrance checklist:

Meds	☐	Birth Certificate	☐	Immunization record	☐	Rights sign-off (individual)	☐
Court order papers	☐	Eligibility papers	☐	Social Security card	☐	Rights sign-off (guardian)	☐
Current Dr's orders	☐	ID card	☐	Release of information (HIPPA)	☐	Photo taken	☐
Medical card	☐	Guardianship papers	☐	Hepatitis B status	☐	Referral packet	☐
MAR/TAR	☐	Body check (attached)	☐				

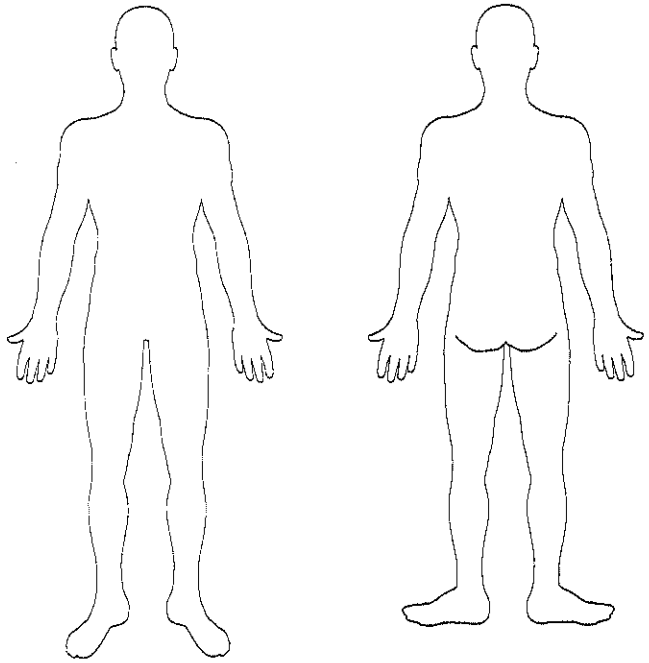
Environmental changes needed:

LIST:	DHS 4612 Work order ☐	Completion date:	Completed	Date
	Yes ☐ No ☐			
	Yes ☐ No ☐			
	Yes ☐ No ☐			
	Yes ☐ No ☐			

Name: _____ DHS prime #: _____ Meeting date: _____

Notes:

Note injuries on diagram below:



NOTE: If injuries are discovered upon admission, Incident Report (DHS 4595) is to be completed, entry recorded in Medical Progress Notes (DHS 4596), and completion of daily follow up on all injuries until resolved.

Name: _____ DHS prime #: _____ Meeting date: _____

Risk Tracking Record (RTR) Completed ☐: **List changes and updates needed:**

Signatures			
Signature of meeting participants	Relationship to supported person	Date	(✓) Agree - Needs can be met

Name: _____ DHS prime #: _____ Meeting date: _____

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Referral Packet Content Checklist

SOCP 2.003 Program Policy: Exit/Transfer – Internal Client Moves guidelines

Each referral packet must contain the following:

- ☐ A cover letter detailing reason for referral, and what kind of service is being sought and who to contact at the referring county.
- ☐ A completed and signed Application or Referral for Developmental Disability Services, DHS 2230
- ☐ Copy of the individual's eligibility determination document
- ☐ Statement indicating the individual's safety skills: i.e. ability to evacuate, adjust water temperature
- ☐ Brief written history of behavioral challenges including supervision and support needs
- ☐ Medical history and information on health care supports that includes, where available
- ☐ Results of a physical exam made within 90 days prior to an entry
- ☐ Results of any dental evaluation
- ☐ Immunization record
- ☐ Record of known communicable diseases and allergies
- ☐ Record of major illnesses and hospitalizations
- ☐ Record of current or recommended medications, treatments, diets and aids to physical functioning
- ☐ Copies of documents relating to guardianship, conservator ship or health care representative
- ☐ Copies of any documents relating to legal restrictions on the rights of the individual
- ☐ Written documentation that the individual is participating in out of residence activities including school if under age 21
- ☐ Copy of the most recent Functional Behavioral Assessment
- ☐ Copy of the most recent Behavioral Support Plan
- ☐ Copy of the most recent Individual Education Plan, if applicable

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Work order form

Date/time of request: _____

Person requesting assistance: _____

Site phone: _____

Name of home: _____

Detailed description of work order type:

Signature

_____ _____

Site manager's signature Date

Fax to: 503-378-5918

Estimated/final cost for project: _____

Estimated date/time project completed: _____

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Health List

Name: _____

Completed by: _____ Date: _____

Annual Medical History: *Summarize any major and/or chronic illness, hospitalizations and injuries.*

Condition – Describe the problem, issue or risk and include the signs and symptoms	**Prevention** – What treatments, medications or therapies are in place to manage or minimize this condition. *See MAR/TAR for specific medications and dosages*	**Intervention** – How do you respond if this condition occurs or worsens? For example; when would you call the PCP or when do you call 911?

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Health List

Name: _____

Condition – Describe the problem, issue or risk and include the signs and symptoms	**Prevention** – What treatments, medications or therapies are in place to manage or minimize this condition. *See MAR/TAR for specific medications and dosages*	**Intervention** – How do you respond if this condition occurs or worsens? For example; when would you call the PCP or when do you call 911?

Completed by: _____ Date: _____