# WYANDOTTE COUNTY
# DEVELOPMENTAL DISABILITIES ORGANIZATION

**FORM: CDDO 27-1**
**Reviewed 08/03/2011**

## TRANSITION OF LICENSED SERVICES

Individual's Name: ____________________ DOB: __________________

Address: ____________________________ City, State, Zip: _______________________

Social Security: ______________________ Medicaid Number: ___________________________

### CURRENT SERVICE PROVIDER

| Type of Service | Provider |
| --- | --- |
| | |
| | |
| | |

### SERVICE CHANGES

| Type of Service | Provider | Effective Date |
| --- | --- | --- |
| | | |
| | | |
| | | |

**TMC hours used:** _____________________ **TMC hours remaining:** ______________________

Case Manager

______________________________________________________________ ______________________
Signature Date

_________________________________________________________________________________________
Print Case Manager Name

Support network including current and new service providers involved in the transition process.

| Name | Organization |
| --- | --- |
| ___________________________________ | ___________________ |
| ___________________________________ | ___________________ |
| ___________________________________ | ___________________ |
| ___________________________________ | ___________________ |
| ___________________________________ | ___________________ |
| ___________________________________ | ___________________ |
| ___________________________________ | ___________________ |
| ___________________________________ | ___________________ |

Consumer: ___________________________________ ___________________
Signature Date

Guardian: ___________________________________ ___________________
Signature Date

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I certify that the parties involved in the services changes shown have been notified of the changes and the effective date of each change.

___________________________________ ___________________
Signature WCDDO staff Date

___________________________________
Print Name

Attach the following items:
New Plan of Care
Transition plan meeting minutes