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|  |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **Waiver Stabilization Services** **Progress and Transition Report** |
| CLIENT’S NAME | CASE MANAGER’S NAME | PROVIDER / PROVIDER AGENCY |
| DATE STABILIZATION BEGAN | DATE OF REPORT | DATE OF TRANSITION FROM STABILIZATION |
| What stabilization service is this report covering?[ ]  Stabilization Services – Life Skills[ ]  Stabilization Services – Staff and Family Consultation |
| What is the identified goal(s) of Stabilization? Please indicate the category that the Stabilization goal is under. |
| Summarize strategies and progress towards goal(s) during the Stabilization period. |
| What is the transition plan for this individual? Indicate what you have done to support a smooth transition for this individual. Stabilization Services are allowed up to 90 days. |
| List any referrals, recommendations or concerns regarding the support and transitional needs this individual has. |
| When did you provide Stabilization Services (dates / times of service in the last 90 days) *(for any additional time / dates when you provided this service, please attach to this report):* |
| **Date** | **Service Delivery (check delivery method)** | **Time spent in 15 minutes** | **date****In person** | **Service Delivery (check delivery method)** | **Timespent in15 minutes** |
| **In person** | **teleservice** | **In person** | **teleservice** |
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| **Signatures** |
| CLIENT’S SIGNATURE DATE |
| LEGAL REPRESENTATIVE’S SIGNATURE DATE | LEGAL REPRESENTATIVE’S PRINTED NAME |
| PROVIDER’S SIGNATURE DATE |

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| **Instructions for Stabilization-Life Skills and Stabilization-Staff and Family Consultation Services** **Progress and Transition Report****Client Name:** Add the name of the client.**Case Manager Name:** Include the name of the client’s case resource manager.**Provider Name:** Add the provider’s name who is working directly with the client. If working with an agency, indicate the agency where the provider works.**Date Stabilization service began:** When did the authorization for this Stabilization Service begin?**Date of Report:** This is the date this form is being written.**Date of Transition from Stabilization:** When will the individual transition out of Stabilization Services? This should not be more than 90 days from the beginning of the Stabilization Service authorization. **What stabilization service is this report covering:** Which Stabilization Service is this report reviewing? This report cannot cover both services. A separate form must be completed for each Stabilization Service.**Summarize strategies and progress towards goal(s) during the stabilization period:** Indicate what you have done to support a smooth transition for this individual. Stabilization services are allowed up to 90 days.**What is the transition plan for this individual?** This section must identify if a new provider will take over, if the client will transition to standalone services. What does the support system look like if not pursuing standalone (ex. if receiving Residential Habilitation). **List any referrals, recommendations or concerns regarding the support and transitional needs this individual has.** If the client presents with potential underlying medical, mental health, or educational support needs (referral may be to Care Coordinator, treating professional, or DDA), list in this section any referrals necessary for the client that are outside of what Life Skills or Staff and Family Consultation services can provide. **Dates and Times of service in the last 90 days:** Document here when and how the Stabilization - Life Skills and Stabilization - Staff and Family Consultation service was provided to the individual.**Client Signature:** The client must sign here.**Legal Representative Signature:** When applicable, the client’s legal representative needs to sign here, agreeing to the progress report. **Provider Signature:** The provider of the waiver service will sign here. |