

Name: _____

Initial Transition Visit: _____

DOB: _____

Initial Visit Date: _____

Living Arrangement

With Family _____

Adult Foster Care _____

Shelter Care/ Group Home _____

Semi-independent (supervised) _____

Shared Living (roommate) _____

Independently (house/apartment) _____

Are skills/resources present for above indicated arrangements? ___ Yes ___ No

Referrals made: _____

Transportation

Independent (bike, own car) _____

Public Transportation _____

Specialized Transportation _____

Are skills/resources present for above indicated arrangements? ___ Yes ___ No

Referrals made: _____

Medical (Name of Medical Staff)

Prosthetic/Orthopedics _____
(_____)

General _____
(_____)

Orthopedic _____
(_____)

Physical Therapist _____
(_____)

Occupational Therapist _____
(_____)

Referrals made: _____

Insurance

SSI/SSDI _____

Medical _____

Referrals made: _____

Employment

Competitive employment _____

Full Time Part Time

Supported employment _____

Volunteer Work _____

Workshops _____

Are skills/resources present for above indicated arrangements? ___ Yes ___ No

Referrals made: _____

Leisure & Community Participation

Recreation Council _____

Agencies _____

Life Skills Foundation _____

Drivers License/ID Card _____

Voting Registration _____

Banking _____

Assistive Technology _____

Referrals made: _____

Education

College _____

Work Training _____

Technical School _____

Are skills/resources present for above indicated arrangements? ___ Yes ___ No

Referrals made: _____

Advocacy/Legal

MPACT _____

Independent Living Center _____

Adult organizations _____

Information seeking _____

Guardianship _____

Wills/Trusts _____

Are skills/resources present for above indicated arrangements? ___ Yes ___ No

Referrals made: _____

Other:

