TRANSITION CHECKLIST

Name: _____
Target date of transition (3-6 month minimum): _____
Person(s) completing checklist: _____

1. **Wellness Plan/Relapse Prevention Plan**
    a. Is there a current plan: Yes No
        i. If no, who is going to create/update one? _____
    b. Plan identifies strengths: Yes No
    c. Plan identifies early warning signs: Yes No
    d. Plan specifies actions to be taken by the individual and others when these signs occur: Yes No
    e. Plan is realistic and has been tested: Yes No
        i. If no, who is going to review this with the person? _____
    f. The person has identified one or more key individuals to advocate in case of relapse
        i. Individual has a copy of plan or has been offered a copy: Yes No

2. **Crisis Plan:**
    a. Is there a current plan: Yes No
        i. If no, who is going to create/update one? _____
    b. Does the plan include current demographics: Yes No
    c. Does the plan include crisis resources for both the person and their natural support system: Yes No
    d. Does the plan include history of effective and ineffective interventions and preferences about medications/strategies: Yes No

3. **Medical staff:**
    a. Is the person choosing to establish traditional western (allopathic) medical care? Yes No
    b. Is the person choosing non-allopathic care? Yes No
    c. Has an appropriately qualified ongoing doctor, nurse, or provider been identified: Yes No
        i. If yes, is there a current Release of Information on file: Yes No
        ii. Has the person has met and accepted the provider: Yes No
        iii. What type of insurance does the person have: _____
    d. Has a copy of the person's most recent assessment, medication history and relapse plan been sent to the medical practitioner: Yes No
        i. If no, who will send this information: _____
    e. How is the person going to access transportation to these appointments: _____
        i. If this is not known, who will help establish this plan: _____

4. **Counseling/Therapy (for example: mental health, pastoral) and/or Case Management:**
    a. Does the person want continued counseling or case management services: Yes No
        i. If so, have they identified the future counselor: Yes No
        ii. Has the person met and accepted the counselor: Yes No
        iii. Has a Release of Information been signed for the new counselor: Yes No
    b. Does the natural support system or family want continued counseling: Yes No
        i. Has the support system been given the names of 3 possible referrals: Yes No
    c. How is the person going to access transportation to these appointments: _____
        i. If this is not known, who will help establish this plan: _____

5. **Complementary and Alternative Medicine (CAM) and healing supports:**
    a. Does the person want CAM or additional healing supports: Yes No
        i. If so, have they identified the location and service: Yes No
        ii. Has the person met and accepted the care provider of these services: Yes No
        iii. Has a Release of Information been signed for the new care provider: Yes No
        iv. Does the person and/or their support network have the financial resources they need to access care for a short term or extended length of time? Yes No
    b. How is the person going to access transportation to these appointments: _____
        i. If this is not known, who will help establish this plan: _____

6. **Medications:**
    a. Is the person prescribed medications: Yes No
        i. Where do they currently access medications? _____
        ii. How are they going to continue to access medications? _____
        iii. Who is going to prescribe the medications? _____
    b. Access to medications have been established for the next 3 months Yes No
    c. Person knows how to secure future medications Yes No

7. **Housing:**
    a. What is the person's current housing situation? _____
    b. Is the current housing situation safe and stable? ___ Yes _____ No
    c. Is the person interested in or needing an alternative housing situation? __ Yes ___ No
    d. What support or resources does the person need to access safe and stable housing?:_____
    _____
    _____
    _____
    e. How will the person access these supports or resources (Family member or other primary support, social service agency, campus housing services, etc.)?:
    _____
    _____
    _____

8. **Transportation:**
    a. What forms of transportation has the person used to access in person:
        i. Mental health care appointments _____
        ii. Physical health care appointments _____
        iii. Social events and community meetings _____
        iv. Work/volunteering _____
        v. School _____
    b. Which of these has the EASA team or agency provided direct access to and/or resources to support (*for example: gas vouchers, bus passes, ride share, medical transport*)?
    c. What access does the person, and/or family or support network, need after EASA to these resources? _____

9. Communication:

a. What type of communication has the person used to make needed connections with other people, groups, employers, agencies, etc.? (*for example: personal cell phone, family landline, agency provided cell phone, computer or tablet, dropping by clinic in person, team member meeting person to bridge communication needs or use laptop/cell phone/etc.)*
b. What communication need to be addressed and planned for (f*or example: person uses wifi when they come to their EASA appointments but does not have access after EASA*)?

10. Treatment Goals:

a. Person has completed treatment goals or has a clear path for completing them. Yes No
b. Goals have been reviewed and mutual agreement has been established that they have been met adequately. Yes No

11. Support System Transition Plan:

a. Natural support system members have been consulted and are in agreement that the person is ready for transition
b. Meeting has occurred and transition Wellness Plan and/or Crisis Plan

_____ _____
EASA participant signature Date

_____ _____
EASA family member/ support person Date

_____ _____
EASA team member(s) signature Date