

## Name of SOC/OHTI Site: Transition Plan

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Date Developed:

Date(s) Reviewed/Updated:

Young Adult's Name:

Team Members Present:

1. Long-Range Vision Goal:
2. Team Mission:
3. Strengths:
4. Lessons Learned From/Achievements Made During the Wraparound Process:
5. Continuing Needs:
6. What to do if symptoms come back or if additional services are needed?

Referring to/continuing services with:

Address	Phone	Appointment date	Appointment time

Medications	Time	Special Instructions

- Updated SNCD (w/in last 3 months)  
Date of last update: \_\_\_\_\_
- Young Adult has demonstrated how to facilitate Transition Team Meeting
- Young Adult has demonstrated how to develop Functional Assessment/Crisis Plan
- Updated Functional Assessment/Crisis Plan  
Date of last update: \_\_\_\_\_

What is the plan to ensure that the young adult is contacted 1 time per month for three months after graduation?

Person responsible \_\_\_\_\_

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Dates of Follow-up \_\_\_\_\_

Participating in services at discharge/graduation

Not participating in services at discharge

NAME	PHONE NUMBER

**Signatures and Dates:**

\_\_\_\_\_  
Young Adult/Date

\_\_\_\_\_  
Team Member/Date

\_\_\_\_\_  
Parent/Guardian/Date

\_\_\_\_\_  
Team Member/Date

\_\_\_\_\_  
Team Member/Date

\_\_\_\_\_  
Team Member/Date

\_\_\_\_\_  
Care Coordinator/  
Transitional Facilitator/Date

\_\_\_\_\_  
Team Member/Date

\_\_\_\_\_  
Family Support Provider/  
Transitional Mentor/Date

\_\_\_\_\_  
Team Member/Date