Transition Health Care Checklist: Preparing for Life as an Adult

A resource to help youth and young adults with special health care needs and disabilities make a successful transition to adult living that includes their education, health and community living

Wisconsin Community of Practice on Transition
Practice Group on Health

The Wisconsin Community of Practice on Transition is comprised of a statewide group of key stakeholders who join together to continue to improve collaboration among agency representatives and community partners. The Community on Transition provides a vehicle to share information, bring forth emerging issues and problem solve. Practice groups form around topics of interest, bringing stakeholders together to share their work. The Practice Group on Health recognizes that health is a critical part of every person and must be incorporated into all aspects of transition.

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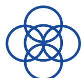

The Waisman Center is dedicated to the advancement of knowledge about human development, developmental disabilities and neurodegenerative diseases. It is one of 9 national centers that encompass both an Intellectual and Developmental Disabilities Research Center designated by the National Institute of Child Health and Human Development, and a University Center for Excellence in Developmental Disabilities (UCEDD) designated by the Administration on Developmental Disabilities.

To view or download a copy of *Transition Health Care Checklist: Preparing for Life as an Adult*, go to http://www.waisman.wisc.edu/wrc/pub.html

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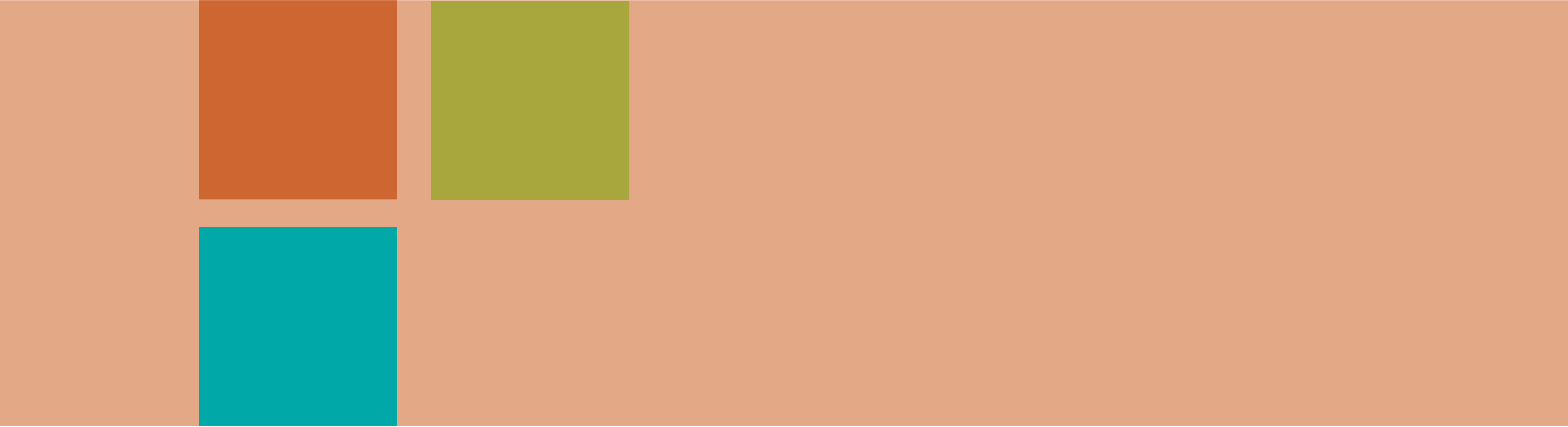

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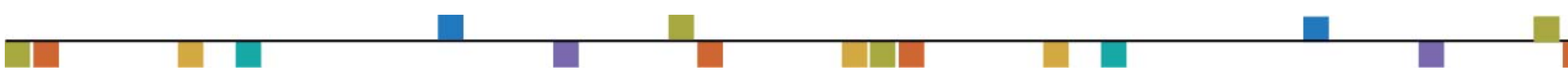

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About This Booklet

Overall Purpose
The *Transition to Health Care Checklist* booklet is intended for youth and young adults who are preparing for the transition to life as an adult. The purpose of the booklet is to provide a general overview of the knowledge, skills and actions that need to be addressed as part of the fluid process of adolescent transition for youth with special health care needs.

For Youth and Young Adults
Congratulations—by opening this booklet, you have taken the first step in a multi-step process that will help you face some important changes as you move toward living as an adult. That move from youth to adulthood is called transition. This booklet is meant to help you with transition planning in Wisconsin.

Transition planning is about future education and work plans, living arrangements, and finances. It is about how to manage a health care condition or disability as independently as possible. You will learn a lot about all these topics in this booklet. Because there are many parts of transition planning, you and the people who help you with transition planning may use several resources like this one. You may use some other resources that focus on such issues as employment, self advocacy, and community services and supports. And at any one time you may only need to use part of the booklet or part of the Skills Checklist. Just use the parts that you need at any given time.

This booklet is meant to help you identify the skills you will need for independent adult living. You can use the Skills Checklist in the middle of this booklet to identify some of those skills. Other parts of this booklet are meant to help you get familiar with issues related to transition. This booklet is designed for you, your family, and the school, health care, and other staff who may be helping you. Everyone who helps you with transition planning is part of your transition team. This booklet is designed to help you and your transition team from the start of transition planning through your completion of high school.

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Preparing for Transition

Transition is a time for learning new information, developing new skills, making decisions and taking action. All of this involves some important planning. This section is about some of the basic things you need to do to prepare for transition, and how this booklet can help you.

What do I need to do?	How can this booklet help me?
Understand Transition You will need to learn about the services, benefits and options available to adults.	Look through the Timeline and Fact Sheets. This information will probably raise many questions for you and you can ask for help from the people who support you.
Develop Skills You will need to develop some skills to be as independent as possible.	The Skills Checklist can help you identify adult living skills that you want to address. Once identified, work with your team to find ways to develop these skills.
Make Decisions and Take Action You will need to look at the choices you have and make some decisions based on what you want and need.	Information on making transition plans will help you to decide how to document your decisions and the actions that you need to take to make a decision a reality

Get More Help...

A **Glossary of Abbreviations/Acronyms** begins on page 47 and spells out the frequently used terminology. Important abbreviations/acronyms and transition terms will be in **bold**.

Understanding the Transition Timeline

Age 14 or Before	Age 16	Age 18	Age 21
Start thinking and talking about transition from pediatric to adult health care services	Begin to update your evaluations and assessments including educational, medical and psychological	You have the right to make all your own decisions about health care. You may consider other decision-making options, including having someone else help you to make decisions	Transition to adult health care providers should be complete unless special provisions are made
Transition services must be included as part of the IEP			
You have the right to be part of the IEP transition team	Schools should facilitate your enrollment in a driver's education course and encourage obtainment of a driver's license if appropriate	Guardianship, Power of Attorney, Power of Financial Attorney and a Medical Directive must be in place if needed	This is the last year you are entitled to Special Education Services through the public schools, if you did not previously graduate
Consider your interests and preferences and how these connect to your future educational, work, health and medical plans	Consider job shadowing in the community and part-time employment options during summer or after school to gain job experience	Take action to transition to adult health care providers	At exit from public school, the school must provide a summary of your academic and functional performance, including recommendations on how to assist you in meeting your post-secondary goals
		Contact private insurance companies about continued coverage	
Start thinking and talking about plans for additional schooling, work and future living situation	Learn more about your eligibility for services and when to apply. Explore adult long-term care options available	Apply for SSI, and reapply for Medicaid programs as an adult, if you may be eligible	Living situation and employment should be secured
	At 17 years, 9 months get screened for long-term care eligibility	Enroll in adult long-term care program if you are eligible	Enroll in adult long-term care program if you have not already done so and if you are eligible
		Make decisions about future plans for work, additional schooling, and living situations	
		Males need to register with Selective Service	
		Register to vote	

Continue to develop social skills and interests in community and recreational activities throughout the years. Also continue to develop decision making and independent living skills including preparing food, shopping, budgeting, cleaning and managing personal finances.

Developing Skills for the Future

Transition is about preparing for life as an adult which may include:

- caring for your own health and medical needs
- attending a university or community college
- getting job training
- getting a job
- living away from home
- getting around the community
- engaging in individually meaningful activities

What skills do you have now?

What skills will you need?

How are you going to develop the skills you need?

Transition begins by the time you are 14 years old

Many important changes in services and legal status occur between the ages of 18 and 21. But planning for transition may begin before you turn 14 years old, and may continue beyond when you turn 21 years old. For many young adults, much of the transition planning happens between 14 to 21 years of age.

Transition is about developing needed skills

All youth need to develop skills to support adult life and independent living. To help prepare for life as an adult, you can think about what skills you need to develop. As you develop the skills keep thinking about what skills you want to work on next. The Skills Checklist can help you identify many skills you will need for independent living and management of a special health care need. You can use the Skills Checklist to identify which skills you have now, and which skills you can work on developing.

Learning about the parts of transition

There are many pieces to the transition process, so it may be helpful to think about transition in three parts: health care, education, and community living. You can learn more about these parts of transition on the following pages. You can use the *Fact Sheets for Making it All Happen* section to learn more about specific topics that may be important for your transition planning. For example, you can learn more about work, insurance and paying for services, financial and legal issues, and assistive technology.

Get More Help...

In this booklet, you'll find shaded "***Get More Help...***" boxes like this one telling you about more resources that might be helpful to you.

You'll find other important resources listed in the section called "Additional Resources."

Transition Planning: Make Decisions and Take Action

Transition planning starts with you

A transition planning process includes the steps you take to move into the adult world. There is new information that you will need to learn about, independent living skills to develop, decisions to be made and actions to take. You are the most important person in planning your own transition. But you don't have to do it alone. Others can help you by providing information, meeting with you to listen to your hopes and dreams for your future and by assisting you to develop a transition plan.

There is no one way to make a plan. Many people find that writing down a plan is helpful. This can keep everyone informed and focused. There may even be more than one written plan. For example, you may have a written transition plan with your primary health care team or other health care provider, school plan such as the **IEP**, and a written plan such as a county-based program's individualized service plan.

The next section of this booklet is all about how to get started with transition planning. You'll learn about a few important places where transition planning will happen, who can help you, and how to work well with everyone on your team.

Get More Help...

WI First Step is a public health information and referral hotline for children and youth ages birth to 21 with special needs, serving families and professionals.
800-642-7837 (toll free); online resource database at **http://www.mch-hotlines.org**

WI Regional Centers for Children and Youth with Special Health Care Needs (CYSHCN) staff answer questions, provide information and referrals, and provide free and confidential assistance to youth with special health care needs and their families and providers. To find out which of the five Regional Centers serves your county: **http://www.dhs.wisconsin.gov/health/children**

National Healthy and Ready To Work (HRTW) Center has electronic links to a variety of transition planning processes. Visit the Center website at
http://www.hrtw.org/tools/check_transition.html

Getting Started with Transition Planning

Now that you know a little bit about what transition planning is all about, you need to know how to get started! Transition planning is a process that evolves over time. As you go through this process, you will try things out and make decisions about what works best for you. So don't worry about making just one transition plan that does it all. It's a work in progress, and it can change as you continue to explore new possibilities and make choices that work for you. As you grow and change, your transition plan should grow and change.

Transition Teams

Transition planning is a team effort

You are the most important person in planning your own transition. What you need and what you would like for your future are the highest priority. But while you are the lead in your transition, many young adults benefit from having others to help with this process. Anyone who works with you and your family can help you to develop specific transition plans. It might be helpful to think of you and these other helpers as your own transition team. You might include people on your team like your family, friends, primary and specialty health care providers, teachers, principals, school administrators, school and community therapists, school nurses, social workers, **Division of Vocational Rehabilitation** (**DVR**) counselors, mental health providers, county-based program providers, and anyone else you choose to include.

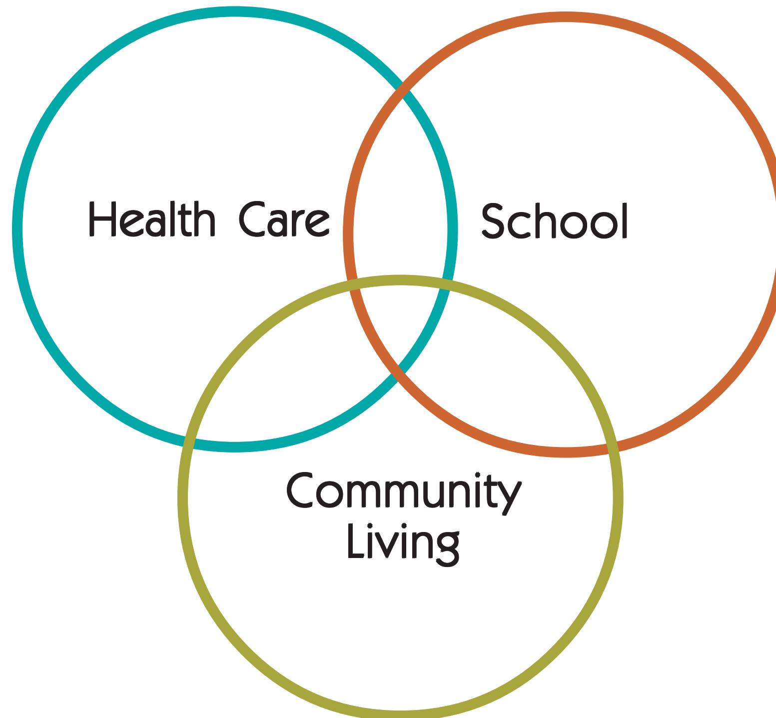
Everyone who helps you with transition planning is part of your team

All of the people who help you with transition are part of your transition team.

- The purpose of the **transition team** is to support you to make the transition to adult living and be as independent as possible.
- The **transition team** includes everyone who helps with transition planning and services.

The big transition team is made up of some smaller teams

Transition planning actually happens in more than one place. So it may feel like there are actually several transition teams! This is because you will do transition planning in health care, education, and in the broader community. It may be helpful to think about the people who help you with each part of your transition as a smaller team. There may be a **health care team,** an **Individualized Education Program** (**IEP**) **team,** and a **community living team**. Each team has a specific purpose. Sometimes different people are on these teams. For example, your primary care physician is an important member of your **health care team**, but may not participate in your **IEP** meetings. Sometimes the same people are on more than one team.



- The purpose of the **health care team** is to plan and support your transition from pediatric to adult care. You can work with your health care team and school team to make sure your health and medical goals are reflected in your **IEP.**

  The **health care team** includes you and your family, primary care provider, speciality care, medical care staff, and other health care providers.

- The purpose of the **school team** is to develop and implement an **Individualized Education Program**. The **school team** will work on the transition plan to be included in your **IEP**.

  The **school team** includes you and everyone who is formally involved in developing your **IEP**. At a minimum, it must include: you, one of your parents, a regular education teacher, a special education teacher, and an **Local Education Agent** (**LEA**) (a school district representative).

- The purpose of the **community living team** is to help you plan and support your transition to adult living, including your job and the informal supports and community-based services.

  The **community living team** includes everyone involved in helping you plan and live within your community, including county-based program staff.

Transition Planning in Health Care

Everyone transitions to adult health care
Shifting from pediatric to adult health care is a transition all young adults make, though if you have a family medicine doctor who sees patients throughout the lifespan, you do not have to switch doctors. In preparation for adult life, young adults with a variety of conditions or disabilities must consider how to manage their own health care needs. Everyone needs to know when to seek medical care and when to take medication. It is important for you to understand your health condition or disability. It is also important for you to understand health risks, how to make healthy life choices, and how to exercise independence in health-related issues.

Integrate goals into your IEP
Health-related goals can and should be included in your **IEP**. The Skills Checklist on page 15 lists many issues that might need to be addressed as part of the transition plan. It can be used to help develop goals to be included in your **IEP**.

Seek coordinated care
The place you go to for most of your general medical care is your primary care site. Some call it your **Medical Home**. An on-going relationship with a primary care physician or nurse practitioner can provide a place to look at your needs as a whole individual. The primary care doctor and team should take a lead in helping you leave pediatrics and move into adult health care. They should make sure you are finding and linking to the health-related services you need at home and in the community

Include all relevant people
Think of all of the health professionals who are in your life now and how these people can help you in the transition process. You may have a strong relationship with a specialty care provider and team. It is important to ask them to help you identify adult specialists and begin the process of transitioning your care to an adult specialty clinic, since almost everyone stops getting care from pediatric specialists by the time they are between 18 to 21 years old. If personal care workers, nurses and/or therapists help you at home, you will want to ask about whether this service will change or end when you become an adult.

Get More Help...

Medical Home is an approach to provide high-quality coordinated, cost-effective health services. To learn more, see "**Medical Home**" in the resource section of this booklet, or visit **http://www.wimedicalhometoolkit.aap.org**

A Medical Home care plan can be downloaded online at **http://www.uwppc.org/resources**

An **Emergency Information Form** is available online at **http://www.aap.org/advocacy/eif.doc**

Health Care Communication Basics

People sometimes say that communication is a two-way street. But when it comes to communication and health-related issues for youth, it is usually a three-way street:

parent(s) + school staff or health care provider + youth

Transition is a time of changing roles and expectations. It is a time for you to actively assume more responsibility. It is also a time for parents and health care providers to encourage this change to the greatest extent possible, even when youth have special health care needs. Open communication is essential to this process so the three-way street becomes:

youth + school staff or health care provider + parent(s) as needed

Key Questions for Youth, School or Health Care Provider and Parents

- Do I show others the respect I want to receive?
- Do I listen carefully and completely to questions or comments before responding?
- Do I participate in discussions willingly and with an open mind?
- Do I accept responsibility for my actions and opinions?
- Do I ask for further explanation when I don't understand something?
- Do I actively participate in planning and problem solving?

Key Questions for Youth

- Do I participate in my appointments by offering information, answering questions, expressing my concerns and asking questions?
- Do I express my own thoughts and feelings even when they differ from my parent(s) or school/health care providers?
- Do I ask for some time alone with my school nurse or health care provider at my appointments for private discussion, and am I able to ask questions without feeling embarrassed?

Key Questions for Providers

- Do I focus my attention primarily on the youth rather than the parent?
- Do I discuss topics that are age and developmentally appropriate and include but are not limited to the youth's special health care needs?
- Do I offer the youth time alone for private discussion?
- Do I respect confidentiality as much as possible?
- Do I create a comfortable environment that encourages collaboration?

Key Questions for Parents

- Do I actively encourage my son or daughter to participate as fully as possible?
- Do I actively encourage the school and health care provider to do the same?
- Do I facilitate confidential communication between my son or daughter and his or her providers to the greatest extent possible?
- Do I recognize my own legitimate needs as a parent during the transition process and seek appropriate supports and resources to meet these needs?

Transition Planning in Education

IDEA 2004
Federal regulations require transition planning to be included in the **IEP** the year a student turns 16.

In Wisconsin
When a student reaches the age of 14, the **IEP team** must formally begin planning for the student's transition to life beyond high school.

It begins when you are 14 years old
In Wisconsin, post–high school outcomes based on age-appropriate transition assessment are required to be part of a student's **IEP** beginning in the year you reach 14 years old. However, the earlier you and all members of your overall transition team and your **IEP team** begin to think about what you will need or will do after high school, the better prepared everyone will be to make the plans become a reality.

It ends by the time you are 21
Once you graduate from high school or reach the age of 21, help is no longer available from the public schools, though, if you turn 21 during a school year and have not graduated, you may finish out the school year. To avoid gaps in services, you must have adult services in place before graduation or before the school year in which you turn 21.

Include all relevant people
As part of the planning process, your **IEP team** must invite any outside agencies that are likely to provide or pay for transition services to participate. This may include representatives from agencies such as **DVR**, the county human services agency or **SSA**. It is important to have community agencies involved in the process as early as possible so they can help with the necessary planning and preparation.

Relevant, meaningful experiences
Transition planning continues throughout high school with instruction, job exploration and community experiences to support your post–high school outcomes. Planning will include choosing a course of study that provides the experiences needed for you to be successful as an adult. The course of study should also be meaningful and motivating to you.

Get More Help...

WI FACETS provides training, information, referrals, and individual assistance related to special education and **IEP**s. It serves youth and adults with disabilities, their families and those who support them. Contact them by phone at **1-877-374-4677** or online at **http://www.wifacets.org**

Wisconsin Statewide Transition Initiative (WSTI) and the Community of Practice on Transition along with local school districts, county social or human service agencies and the medical community offer support for students and their families to ensure the transition from high school to adult life is made smoothly. You can visit the **WSTI** website at **http://www.wsti.org**

Transition Planning for Community Living

Transition means change
You may choose to live with your family into adulthood, or you may want to experience independent living. Maybe you will go back and forth between living with your family and living independently. But no matter which choice you make, most community-based resources and services change with the move from childhood services to adult services. The Family Support Program, for example, does not continue into adulthood. Other resources like how to get supported at the work place, will be new to you. It's important to plan for the transition from the childhood service system to adult services. Your community living team is made of the people who help you plan this transition.

Skills for community living
Regardless of where you live as an adult, you will need to develop skills to be as independent as possible in your daily life as an adult in a community. Some important skills for adult living include knowing how to make decisions, making time for friends and family, advocating for yourself, managing activities of daily living, being safe, maintaining a healthy lifestyle, accessing transportation, engaging in recreational activities, and making sure you have health insurance coverage.

Include all relevant people
Support for community-based living comes from agencies as well as informal supports. The community living team may include you, your family, county program service providers, informal supports (friends, faith community, and neighbors), and anyone else who supports you in community-based living. This team will most likely overlap with the health care and school teams. The community living team may engage in a "PATH Futures Planning" or similar process to explore the possibilities for adult life. If you want to learn more about PATH Futures Planning, check out the information at the bottom of this page.

Get current county information
Much of the funding for **Medicaid** and human services is administered at the county level. This means there is a lot of variation in how community-based services are structured in counties across Wisconsin. The state has an adult long-term care system which has options available based on eligibility, county of residence, and some consumer choice. For example, **Family Care** is in the process of expanding throughout the state. Because there are regular changes to services and insurance coverage plans, it is very important to check with the appropriate state, county, or other agencies for up-to-date information on programs available in your area, and whether you are eligible for them.

Get More Help...

If you want to learn more about **PATH** Futures Planning, you can find several resources about the **PATH** process on the website **http://www.inclusion.com/path.html**

Wisconsin Independent Living Centers are consumer-directed, non-profit organizations that provide four core services: peer support, information and referral, independent living skills training, and person and systems advocacy. **http://dhs.wisconsin.gov/disabilities/physical/ilcs.htm**

Identifying Skills for Independence

An important part of planning your transition to living in the community as an adult is figuring out what skills you will need and how you are going to develop them.

This next section focuses on helping you identify the skills you will need for independence. It includes a list of skills that is set up as a checklist. You and your transition team can go through the Skills Checklist and add a check mark to each skill you have now. Then you can work with your transition team to decide which skills you need to develop, and how you will do that. Don't forget to work with your health care, school and community teams to figure out how working on these skills can be written into your transition plans.

This checklist includes many of the skills you will need for independence as an adult. But you and your transition team will probably think of other skills that aren't included here. You can add your own skills to the end of the list. Once you figure out what skills you need to develop, it will take time to develop them. Each year you will probably be able to check off more skills from this checklist.

If you think you might want to fill out a clean copy next year, make copies of the checklist now, before you fill it out. You can photocopy the Skills Checklist before you begin working on it.

Skills Checklist

Communication

- ❑ know how to express an idea, question or feeling
- ❑ let others know what I need
- ❑ know how to arrange for sign language or other interpreter, if needed
- ❑ know how to care for communication devices and use them independently
- ❑ know how to communicate by phone/TTY/TTD
- ❑ have a support person available if unable to communicate verbally
- ❑ know when, why and how to sign my name

Self Awareness

- ❑ know who is involved in decision making and who to trust
- ❑ know my name, address, telephone number and who else may have this information
- ❑ know my height, weight and birth date
- ❑ carry personal I.D. when leaving home
- ❑ wear a medical alert I.D.
- ❑ know where my social security card and birth certificate are and when to use them
- ❑ know when and how to protect my identity and private information
- ❑ know how to describe my medical condition/disability and how it affects my life
- ❑ know my past medical history
- ❑ understand human sexuality

Self Advocacy

- ❑ know how to stop and think and when to say "No"
- ❑ speak up for myself
- ❑ take part in my **IEP** (**Individualized Education Program**) meetings
- ❑ know people who can help me to take part in community activities
- ❑ know what agencies can support me as I become an adult
- ❑ know how to identify services and supports I may need, and know how to identify their eligibility rules and how the services and supports can be paid for
- ❑ know how to make contact with community advocacy organizations
- ❑ know how to call and ask for information, materials and booklets
- ❑ know where to get more information about my medical condition/disability
- ❑ have good communication with doctors and other professionals
- ❑ know about signing a form that will allow doctors to talk with parent(s) or legal guardian when I am 18
- ❑ know when to call the county or **Managed Care Organization** (**MCO**) or **Care Management Organization** (**CMO**) for Persons with Disabilities if I need help paying for services
- ❑ know to apply for long-term support services through my county human service agency or **Aging and Disability Resource Center** (**ADRC**) at 17 years and nine months of age

Skills Checklist

Activities of Daily Living

- ❑ know how to take care of my personal needs (dressing, eating, hygiene and grooming skills)
- ❑ manage basic household chores
- ❑ know how to shop for groceries
- ❑ safely cook and prepare food
- ❑ know how to get a library card
- ❑ know how to read labels and know what they mean or who to ask about them
- ❑ know how to use household cleaners properly
- ❑ know how to do laundry
- ❑ understand Hot and Cold
- ❑ know how to use and read the thermometer to take my temperature
- ❑ know how to treat minor cuts, scrapes, burns and other simple first aide
- ❑ know how to contact utility services
- ❑ know who to call for basic household emergencies, such as power outages
- ❑ know what the landlord's job is and how to contact the landlord
- ❑ know how to care for my teeth and gums

Safety

- ❑ know when and how to protect myself by wearing gloves and safety glasses
- ❑ know how to keep myself safe, such as being aware of strangers, using a seatbelt, being safe crossing the street, etc.
- ❑ understand the safe use of computers and phones
- ❑ understand the proper use of matches
- ❑ have emergency, fire, tornado and disaster plans made
- ❑ respond appropriately to fire alarms, know fire exits and know where the meeting place is located in an emergency
- ❑ have a fire extinguisher and smoke detector and know how to use and maintain them correctly
- ❑ understand who can help
- ❑ know how and when to use emergency telephone numbers, such as "911"

Vision/Hearing

- ❑ use glasses or contact lenses independently as appropriate
- ❑ know how to get and who provides new prescriptions
- ❑ use hearing devices independently
- ❑ ask for accommodations for vision/hearing as needed

Skills Checklist

Nutrition and Fitness

- ❑ understand if I have food allergies and how to safely deal with them
- ❑ understand if I have a specialized diet and how to get medical follow up on my dietary needs
- ❑ understand the basics of good nutrition, including healthy food choices
- ❑ understand funding and budgeting for the purchase of food
- ❑ understand the benefits of a health and fitness program
- ❑ take part in activities that keep me physically fit with modifications as needed
- ❑ know and understand the dangers of smoking, drugs, alcohol and abusive behaviors
- ❑ know where and how to get help to maintain a healthy lifestyle
- ❑ know how to prepare and store food safely

Recreation and Socialization

- ❑ take part in activities with a group of peers/friends
- ❑ take part in activities that allow me quiet time for myself
- ❑ identify activities in the community that are meaningful to me and participate in them
- ❑ know what Day Service programs will be available after turning 18, and have a plan to tour a Day Service program (such as Goodwill Industries, Curative, etc.), if I am not otherwise employed or going to college full time

Transportation

- ❑ know how to use transportation to get from place to place
- ❑ know how to get to doctor's office or other appointments
- ❑ know who can provide transportation and/or how to make arrangements
- ❑ know how to apply for a disabled parking permit
- ❑ understand safety aspects of walking
- ❑ know my home address
- ❑ know about funding or saving money to purchase a vehicle, needed adaptations or services

Legal and Financial Issues

- ❑ know how to apply for Social Security
- ❑ know how medical decision making changes at age 18
- ❑ know about having an Advanced Directive
- ❑ have Power of Attorney issues for health care and finance that have been addressed.
- ❑ have financial trust issues that have been addressed
- ❑ know how to manage money
- ❑ know how to open a bank account

Skills Checklist

Managing Medical Care and Finding a Medical Home

- ❑ understand my medical condition
- ❑ have a primary health care provider who knows me well and helps me in many ways
- ❑ know how to take care of my medical condition by myself at home
- ❑ keep a list of my health care providers, their phone numbers and office hours and carry this list with me when I leave the house
- ❑ have a care plan and understand how to use it in an emergency
- ❑ can describe changes/symptoms caused by my medical condition
- ❑ can call my primary care provider when I am having problems or need to give a progress report
- ❑ know the difference between an emergency (go to hospital) or illness (call my doctor)
- ❑ can follow the plan of care recommended by my doctor
- ❑ know what nursing services I will need and how to get them
- ❑ know how to find out if I am eligible for personal care assistance
- ❑ know how to hire a personal care assistant or get other assistance that I need

Locating Adult Health Care Providers, Finding a Medical Home

- ❑ know the difference between primary care and specialists, and what each provides
- ❑ have talked with current pediatric provider(s) about potential adult provider(s)
- ❑ have considered living arrangements that are close to doctors and medical facilities
- ❑ have prepared questions for doctors, dentists, nurses and therapists
- ❑ have responded to questions from doctors, dentists, nurses and therapists
- ❑ have planned a meeting with new adult provider(s)
- ❑ have evaluated the accessibility of office and exam rooms
- ❑ have arranged for medical records to be sent to new provider(s)

Insurance and Care Coordination

- ❑ understand that insurance plans may have approved providers
- ❑ understand managed care versus fee-for-service insurance
- ❑ can identify what services are covered by insurance plans
- ❑ know my insurance company and how to contact them
- ❑ carry my insurance card when leaving home
- ❑ know how and when to get a referral
- ❑ know how and when to use insurance and when to pay expenses out of pocket
- ❑ understand who assists with coordination of services and how to contact them
- ❑ know how and when to ask for help from case managers or customer service
- ❑ understand that insurance companies may have requirements (such as being a full-time student) in order to remain on my parent's insurance plan
- ❑ understand that when I turn 18 I need to document my disability again and reapply for **Medicaid/Medicare**

Skills Checklist

Managing Appointments

- ❑ keep a calendar of doctor and dentist appointments
- ❑ know how to make appointments for doctors, laboratory tests and diagnostic tests
- ❑ call for referrals if needed
- ❑ write down any questions I have for my doctor and take them to the appointment
- ❑ take part in my doctor's visits

Managing Medications

- ❑ know the names and purpose of my medicines and how and when to take each one
- ❑ know medicine side effects and what to do if they occur
- ❑ take medicine on my own without help from a parent or guardian
- ❑ fill a daily/weekly pillbox
- ❑ know when and who to call for prescription refills
- ❑ call my doctor when I have no refills left on a prescription
- ❑ get medicines refilled without help from my parent or guardian
- ❑ have a working relationship with the pharmacist
- ❑ know to ask the doctor or pharmacist if I have questions or need help
- ❑ know which prescription cards to show when picking up a prescription
- ❑ understand the meaning of "co-pay"

Managing Equipment and Treatments

- ❑ know the purpose of special equipment, treatments or supplies that are needed
- ❑ understand and can do my own treatments and therapies when appropriate
- ❑ know who does my treatments and therapies and how often they occur
- ❑ know how to order medical supplies
- ❑ know how to fix minor problems with equipment
- ❑ know how to arrange for equipment maintenance – both routine and emergency

Managing Medical Information/Record Keeping

- ❑ know how to write down recommendations of the doctor or dentist and have written follow-up given to me
- ❑ keep a record of my medical information (such as clinic notes, test results, immunizations, summaries, functional assessment, etc.)
- ❑ know how to keep records organized
- ❑ know how to complete a medical records release form, and know when I would need to do so
- ❑ have a copy of a summary of medical information
- ❑ know how to designate a Medical Power of Attorney, or I have already done so

Skills Checklist

Work

- ❑ have contacted the **Division of Vocational Rehabilitation** (**DVR**) office and know how to work with them
- ❑ have completed an **Emergency Information Form** (**EIF**) and given it to all who will need it
- ❑ know my rights and responsibilities under the **Americans with Disabilities Act** (**ADA**) and the **504 Rehabilitation Act**
- ❑ have thought about possible careers and looked for information about those careers
- ❑ have learned about jobs by observing other people (such as family, relatives, and friends) at work and by talking with other adults about what they do for work
- ❑ have toured businesses to see what jobs they offer
- ❑ have learned about jobs through opportunities offered at school (classes about careers, tests to find out what careers might be best for me, job fair or job program)
- ❑ have completed a resume and a job application, or I know how to do this
- ❑ have gained paid or volunteer work experience
- ❑ know how to talk about what I need to be successful in a job
- ❑ know how to discuss my accommodation needs with an employer
- ❑ have considered the pros and cons of full-time and part-time work and how these options affect benefits offered

Higher Education

- ❑ know how to get help from my high school counselor
- ❑ know when and how to apply for college and for financial aid and scholarships
- ❑ know what paperwork needs to be completed before starting school
- ❑ know what time management and study strategies work best for me
- ❑ have visited college fairs or toured college campuses
- ❑ can tell my teachers what I need and what I want to learn
- ❑ have asked for special help taking the SAT or ACT tests if needed
- ❑ understand how my disability affects my learning
- ❑ know about my educational options after high school
- ❑ have considered the pros and cons of full-time and part-time school and how these options affect benefits offered
- ❑ have met with the Disability Services office at the college I plan to attend and talked to the office staff about my needs
- ❑ have worked with health services at the college to plan for medical emergencies
- ❑ have requested an updated psychological evaluation (if needed) prior to attending college

Fact Sheets for Making it All Happen

You may still have a lot of questions about transition planning. This next section of the booklet includes some important fact sheets about:

A. Financial and legal concerns
B. Disability benefits
C. Support to find a job
D. Work and disability benefits
E. Medicaid in Wisconsin
F. Private health insurance
G. Assistive technology
H. Mental health services

Some of this information was pulled directly from agency websites or publications. The source of the information is always listed under the Fact Sheet heading. For more information there are website links in the "get help" boxes.

This section contains a lot of detailed technical information. Information like this is often very complicated and it also changes regularly So it is really important to check with the agency listed for the most accurate and recent information. In the meantime, this section is meant to introduce you and your transition team to some of the issues that may be important to you during your transition planning.

A. Financial and Legal Concerns

The following financial and legal information was developed by Roy Froemming, private practice attorney, Madison, Wisconsin.

Meeting needs for decision-making support related to finances, property and self-support
Identify major concerns related to finances, property and self-support:

- Is there a need to protect the young adult's financial resources to ensure payment of bills for basic support?
- Is there a need to ensure that larger resources are protected from loss (e.g. a home, a future inheritance, significant savings or retirement benefits) through poor management, bad decisions or exploitation by others?
- Can the person give a legally valid consent to needed contracts, such as leases?

Consider the following tools and options:
Informal advice and support. Person has access to, and accepts, informal assistance and advice regarding financial management from family friends, service providers and/or advocates.
Assisted financial management and bill-paying. Examples:

- Person gives someone else regular access to bank records, bills, etc
- Person gives someone else authority to write checks on his account
- Income is deposited directly to an account and basic bills are paid automatically from that account

Restricted bank account. Examples:

- Dual signature account requires two signatures to write a check or make withdrawal
- Accounts limit the size of checks that can be written on the account
- Larger sums are kept in account to which young adult does not have independent access

Restrictions on home ownership. Examples:

- Home paid for and owned by parents, other family members or a trust (young adult may or may not pay rent)
- Home is owned by young adult with ownership restrictions to prevent sale or mortgaging
- Home is owned by young adult but ownership interest or equity is limited by a mortgage, life estate or restrictive covenant
- Person is a joint owner or tenant in common

Durable financial power of attorney. A young adult who is competent can appoint someone else (the *agent*) to manage all or part of the young adult's resources. A durable power of attorney means the document will remain in effect (or go into effect) if the person who signed it becomes mentally incapacitated and is no longer able to handle matters on his or her own.

Court-appointed financial conservator. Young adult can voluntarily request the court to appoint a conservator to hold and manage the young adult's resources. The conservator has the powers of a guardian of estate, but the order is voluntary and there is no finding of incompetence.

Trust funded with family resources (third party trust). Parents, family members, or friends can give their resources directly or by will, to a designated *trustee* who has a strong legal duty to use the resources for the young adult who is the *beneficiary* of the trust and to use the resources as directed by the trust document. If carried out properly, the young adult gets the benefit of the resources, without ownership and control.

Trust funded with young adult's own funds (self-funded trust). The young adult can voluntarily place his or her own resources in a trust to be used for his or her personal benefit as directed by the trust document. This is a way to have someone else manage the money and to either give up control or to put limits on his or her own ability to make decisions related to the money.

Representative payee for SSI and/or SSDIB benefits. The **Social Security Administration (SSA)** can appoint someone to receive and spend Social Security or **SSI** benefits on behalf of the young adult, on the grounds that the individual lacks capacity to manage benefits or will not apply benefits to own basic support needs. A representative payee only manages the young adult's Social Security or **SSI** funds, and does not otherwise have authority to sign contracts or control the person's finances or decisions.

Court-appointed guardian of estate. Based on a finding of incompetence, a court appoints a competent adult to be a substitute decision-maker for property and finances. This is the most restrictive option, but can be limited to give the young adult some control over decisions, and carried out in a way that respects the person's wishes and abilities while avoiding unacceptable risks. A finding of incompetence requires a finding that the young adult has a mental impairment, does not have capacity to make decisions, and as a result is at risk of not meeting own support needs or is at risk of losing own major resources.

Get More Help...

Wisconsin Board for People with Developmental Disabilities (WBPDD) publishes a series of resources on community supported living. Some of these resources are available on the WBPDD website at **http://wcdd.org/publications2/index.cfm**

Check out *Making a Difference: Thinking about Decision-Making Support in the Transition Process* which is available at **http://wcdd.org/Publications/making_a_difference.PDF**

Meeting needs for decision-making support related to medical care, treatment and autonomy

Identify major concerns:

- Do other people need access to records or other information in order to advise the young adult, talk to providers, or be present when the young adult talks to providers?
- Are health care and support service providers unwilling to provide beneficial treatments and services, which the young adult would accept, because of concerns about the young adult's capacity to give informed consent?
- Does the young adult make health care decisions (or fail to follow recommended treatment) in ways that are significantly detrimental to own health?
- Is the young adult interested in planning ahead for health care decisions, including end-of-life issues, should the young adult be incapacitated, e.g., due to injury or dementia?

Consider the following tools and options:

Release of medical records and information. Releases can be used to provide family members or others with access to health care information. The release may include authority to receive both written and oral information, and to participate in treatment discussions with providers. Releases must be knowing and voluntary, must comply with state law on release of health care or mental health treatment records, and must comply with federal **HIPAA** law, including notice of the right to revoke.

Ordinary health care power of attorney (HCPOA). A young adult who has capacity can appoint an agent to receive health care and mental health treatment information and to make health care decisions on the young adult's behalf if the young adult later becomes incapacitated. *Incapacity* is defined as unable to manage one's own health care decisions due to inability to receive and evaluate information effectively or to communicate decisions. An ordinary **HCPOA** is only effective if it is activated because the person is found to be incapacitated.

Health care power of attorney with special provisions restricting the right to revoke and the right to refuse. This kind of **HCPOA** has special clauses stating that, if the young adult is incapacitated by an acute phase of the young adult's own mental illness, the person wants the health care agent to be able to authorize certain treatments, regardless of the person's refusal of treatment or attempt to revoke the **HCPOA** while incapacitated. **(**An **HCPOA** of this kind still cannot give an agent authority to admit the person for inpatient mental health treatment over the person's objection.)

Health care power of attorney with special provisions making it effective even when person is not incapacitated. This kind of **HCPOA** adds a provision saying that the young adults wants to give someone else access to health care and treatment records and information, and decision-making authority over health care even when the person is not incapacitated. If the person has capacity and states wishes, those wishes must be honored, regardless of the agent's consent.

Living will. If competent, the young adult can make a written declaration to physicians directing whether the young adult wants life-sustaining treatment and/or feeding tubes used if the young adult is ever in: (1) a "persistent vegetative state" or (2) a "terminal condition" (i.e., death is imminent and treatment would only postpone moment of death).

Do-Not-Resuscitate Order. A physician can make a written **Do-Not-Resuscitate (DNR) Order** directing emergency medical technicians, first responders and emergency health care facilities personnel not to attempt cardiopulmonary resuscitation on the young adult for whom the order is issued if that person suffers cardiac or respiratory arrest (in-patient hospitals may have a different type of **DNR** orders). The young adult must have a terminal condition, or the physician must find that CPR would be futile or would do more harm than good.

Court-appointed guardian. If the court makes a finding of incompetence, it can appoint another person or agency to be a substitute decision-maker for the young adult's health care, treatment, support service and other personal (non-financial) issues. A guardian can be appointed based on findings that the young adult has a mental impairment, does not have capacity to make important decisions, and, as a result, is unable to meet the essential requirements to care for own physical health and safety. The guardian only has the powers given in the order that creates the guardianship. These must be limited so the young adults keeps rights and powers the young adult has capacity to exercise.

Court ordered commitment or protective placement. If the young adult refuses to consent to needed treatment for mental illness, or objects to placement in a residential facility, it may be necessary to get a court order for commitment or protective placement.

Get More Help...

Advanced Directives

The following Wisconsin advanced directives forms are available on the Department of Health Services website at **http://dhs.wisconsin.gov/forms/Advdirectives/index.htm**

- Declaration to Physicians (Wisconsin Living Will)
- Power of Attorney for Health Care
- Power of Attorney for Finance and Property
- Authorization for Final Disposition

The **Wisconsin Guardianship Support Center** (Coalition of Wisconsin Aging Groups) answers questions about the law in Wisconsin relating to guardianships, protective placements, conservatorships, Powers of Attorney for Health Care, Living Wills, DNR orders and Powers of Attorney for Finances. Contact the Guardianship Hotline toll-free at **1-800-488-2596 ext. 314**, or **http://cwag.org/legal/guardian-support** for more information.

Managing assets and resources held by the young adult

Concerns about excess resources:
Excess resources can happen for many reasons, including savings from work, a back payment from Social Security, a settlement in a lawsuit, or an inheritance that was not put into a trust.

- Does the young adult have countable assets in his or her own name that are above the ordinary asset limit for **SSI** or **Medical Assistance**?
- Is the young adult accumulating money because he or she has more current income than expenses?

Consider the following alternatives:
Pay off debts. Pay off any debts, including credit card debts or mortgage loans.

Spend it. There are no limits on how resources can be spent, but there may be penalties if resources are given away or if more is paid for things than they are really worth.

Buy excluded resources. Buy items not counted as a resource, such as furniture, home, computer, car, transportation tickets for future use, and assets connected to burial.

Consider switching to the MA Purchase Plan (MAPP). MAPP helps people who are working continue to be eligible for **MA** by allowing higher asset levels.

Buy or improve a home, or pay off mortgage. If the young adult owns a share in a home, its value and cost of needed repairs or improvements do not count as a resource.

Put it into education, a business, or a PASS plan. Getting more education or investing in something used in a trade or business can reduce countable resources and raise long-term income. Putting resources into a **Plan to Achieve Self Support** (**PASS**) allows the young adult to set aside resources for use as part of a plan to reach an employment goal.

Spend it on health, dental or equipment needs for expenses not covered under **MA**.

Prepay for rent or other expenses. It may be possible to prepay some expenses.
Make an arrangement to put excess resources (or sometimes income) into a special needs trust for young adult. A special needs trust is a way to hold funds for the future benefit of the young adult so the funds do not count as a resource. It is useful if the young adult does not have unmet needs now, but is likely to in the future. If the trust is funded with the young adult's own money, funds left in the trust at the individual's death go to the state (or, in some kinds of trusts, to help other people with disabilities).

Get More Help...

If you are considering prepayment of future expenses, homeownership, or a self-funded special needs trust, you should consult an expert on resource planning for people with special needs. There are many technical requirements, and plans that are not thought through can have unexpected results.

Provision of financial support to the young adult

Concerns about continuing financial support:

- Are you providing financial help to the young adult, and do you want to make sure that help will continue if you are incapacitated or die?
- Do you (or other people) have resources that you would like to set aside to help the young adult, either during your life or when you die?

Consider the following tools and options:

Create a supplemental needs trust This trust holds resources for the young adult, to be used for the individual's benefit by a *trustee*, who is someone responsible for managing and using the funds. The money placed in this trust can be used flexibly enough to meet future needs, and if the trust is written properly, the money will not be counted as a resource for **Medical Assistance** or **SSI**. This trust allows an individual to provide financial support for the young adult in a way that can continue even after the individual can no longer provide support. Funds remaining in this kind of trust when the young adult dies go to a person designated in the trust and are not subject to any type of recovery by the state. If you do set up a trust, make sure that your will, remainder beneficiary designations, or other estate planning documents are written so that property that would otherwise go to the person instead goes to the trust for his or her benefit.

Create a durable power of attorney for yourself, so that someone has authority to use your resources to benefit the person if you are incapacitated, in the ways that you would if you were still able to make decisions for yourself.

Help the person become a homeowner, or buy a home or condo yourself that you can then use to provide housing for the person.

Help the person live better now, by giving the person furniture, clothing and other exempt resources, paying for transportation, paying for things that will help the person get a better job or have a business, or paying for services.

Create a Letter of Intent that sets out what you know about the person and his or her present and future wants and needs, and that tells your trustees and agents how you want your property used to benefit the person, while at the same time leaving flexibility to deal with the person's changing needs and wants.

Consult an expert on resource planning for people with special needs if you are considering prepayment of future expenses, homeownership, or a supplemental needs trust. There are many technical requirements, and plans that are not thought through can have unexpected results.

Get More Help...

Check out *One Step Ahead: Resource Planning for People with Disabilities Who Rely on Supplemental Security Income and Medical Assistance*. It's available online at **http://www.wcdd.org/publications2/Pub_by_cats2.cfm?catid=16**

B. Disability Benefits

The following disability benefit information was adapted from the State Department of Health Services website (http://dhs.wisconsin.gov/ddb/index.htm).

Qualifying for disability benefits through Social Security
The **Social Security Administration (SSA)** offers youth and young adults with disabilities the chance to apply for cash payments and public health insurance (public health insurance has several names, including **Medicaid**, Title XIX, and **Medical Assistance** or **MA**). Since rules and eligibility guidelines change over time, this section offers a summary of what may be available. For the most current and accurate information on disability benefits, contact the closest **SSA** office or visit the **SSA** website at www.socialsecurity.gov. To determine eligibility and to learn more about specific programs that may be available to youth and young adults, directly contact the closest **SSA** office. The **SSA** website may also be used to begin an application for benefits.

Disability determination for purposes of Social Security
The determination of disability for Wisconsin residents is made by the Wisconsin Division of Health Care Access and Accountability, **Disability Determination Bureau (DDB)**.

SSA disability determination is based on the following:
Under age 18 years

- must have "marked and severe functional limitations" resulting from a physical or mental condition or combination of conditions
- condition must last at least 12 months or must be expected to result in death

Over age 18 years

- for an adult, disability is defined as the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment
- condition must last at least 12 months or must be expected to result in death

Get More Help...

For additional information about the transition from SSI benefits as a child to SSI benefits as an adult, visit the National Center for Youth Law website at **http://www.youthlaw.org**

ABC for Health is a public interest law firm connecting Wisconsin families with health care. For more information on the services they provide, visit their website at **http://www.safetyweb.org**

For more information about **SSA**, visit the Social Security Administration website at **http://www.socialsecurity.gov**

For answers to **Medicaid** questions, call the State of Wisconsin Medicaid Recipient Hotline at **800-888-7989** or visit the website at **http://dhfs.wisconsin.gov/medicaid/index.htm**

Monthly cash payment benefit
If the youth or young adult meets the **SSA** disability determination (see above) **and** have limited income and resources, they may be eligible for **SSI**. **SSI** is a monthly cash benefit paid to people in financial need who are blind or disabled, or are 65 years of age or older. Youth who receive **SSI** do not automatically qualify for **SSI** as an adult. An adult eligibility determination needs to be made for individuals who are 18 or older. This means that youth who receive **SSI** need to reapply for the benefit during transition. To prevent interruption of benefits, contact the Social Security office about 3 months before the 18th birthday.

SSI eligibility is based on the following:
Under age 18 years

- income and resources of the child and family
- child/youth disability determination (see description above)

Over age 18 years

- income and resources of the adult applicant
- adult disability determination (see description above)

Social Security Disability Insurance (SSDI)
SSDI is a monthly cash benefit paid to people who have paid into social security and have become disabled and unable to work. Payment amount is based on the actual earnings of the applicant for **SSDI**. It is possible that a young adult may qualify for this benefit, visit the **SSA** web page (www.socialsecurity.gov/pubs/10029.html) or contact your local Social Security office to learn more. For an individual who qualifies for **SSDI**, Medicare takes effect 24 months after this benefit begins.

Social Security Benefits as a Disabled Adult Child (SSDAC)
If youth or young adults meet the **SSA** disability determination (see above) **and** they have a parent who retires, gets benefits because of a disability or has died, the youth or young adult may be eligible for **SSDAC** based on the parent's work history. Benefits may begin at age 18, and Medicare will take effect 24 months after this benefit begins (but not before age 20). Benefits may be payable to a youth under the age of 18, under some circumstances. Contact the closest Social Security office to learn more about eligibility for this benefit.

Medical Assistance benefits
It is important to know that individuals who qualify for SSI automatically qualify for Medical **Assistance (MA)**. Individuals who qualify for **SSDI** or **SSDAC** benefits for 2 years qualify for **Medicare** coverage.

C. Vocational Rehabilitation

The following information has been modified from the Waisman Center's Healthy and Ready to Work (HRTW) Youth Fact Sheets (http://www.waisman.wisc.edu/wrc/pub.html).

Getting help to get a job

The **Division of Vocational Rehabilitation** (**DVR**) helps people with disabilities get a job. It is a federal/state program designed to obtain, maintain, and improve employment for people with disabilities. To make this happen, **DVR** works with consumers, employers, and other partners.

Eligibility for DVR services

Young adults must have a disability that gets in the way of getting or keeping a job. Common types of disabilities are: attention deficit disorder (ADD), cerebral palsy (CP), deafness, blindness, depression, specific learning disability, traumatic brain injury (TBI), or para/quadriplegia. There may be a wait to receive services. **DVR** serves people with the most significant disabilities first. If there is enough money, they then serve people with less significant disabilities.

DVR can provide a number of services

Helping young adults find a job that works for them through:

- career counseling to help identify a career goal
- assessments to identify individual skills
- help finding a job
- help creating a resume

In some cases, helping pay for job-associated costs for:

- mobility training
- appropriate work clothes
- adaptations to car
- academic accommodations at college (for example, tutoring)
- home modifications that make it possible to get to work (for example, a ramp)

Help begins with an Individual Plan for Employment

Before young adults receive services, they create an **Individual Plan for Employment** (**IPE**) with their counselor. The young adult and counselor must both agree to the plan. The plan says what the young adult's job goal is and the services he or she will need to get that job. It is helpful if young adults already know what they are good at (their skills) and what they are interested in doing for work. The **IPE** also says who is responsible for paying for the services.

Sometimes help is available for attending a technical college or university
DVR is not a scholarship program. It is a federally funded program to assist people with disabilities who want to work get the skills they need to become employed. Depending on the situation, young adults may be able to receive financial help with tuition, books and disability-related services (like tutoring and homework aides). Young adults must apply for financial aid with the college or university before **DVR** will consider paying for any college expenses. Then **DVR** may provide financial help with college expenses if this leads to young adults getting a job they are interested in and qualified to do. Most **DVR** counselors require young adults to maintain a certain grade point average to continue receiving financial assistance, usually a 'C' average.

How to apply for DVR services
A counselor can explain **DVR** services, help determine eligibility for services, and fill out an application with young adults who want to apply. It can take several weeks to apply. If there is a waiting list, **DVR** helps people first who have the earliest date on their application. To apply, young adults need to provide documentation of a disability. The application process can be quicker and easier if the documentation of disability and addresses of doctors are available when the application is made.

Building a relationship with the DVR Counselor
The process of finding and keeping a job is much easier when young adults receiving services build a relationship with their **DVR** counselor. Young adults can call or e-mail their counselor regularly with updates about their progress or what they need. Young adults can also build a positive relationship with their **DVR** counselor by providing information that the counselor will need in a timely manner. For example, the counselor will need copies of any financial aid statement, grades, and receipts before **DVR** can pay for services. A positive relationship is also built by asking questions and telling the counselor about individual needs, such as academic accommodations, work accommodations, help looking for a job, or help identifying a possible job.

Get More Help...

Division of Vocational Rehabilitation (DVR) office and application
A local **DVR** office can be located by calling **1-800-442-3477** or visiting the **DVR** website at **http://www.dwd.state.wi.us/dvr**. A counselor can explain eligibility and how to apply

Client Assistance Program (**CAP**) can help young adults understand their rights and the policies of **DVR**. Young adults can appeal to **CAP** if they disagree with a decision made by their counselor. **CAP** also offers mediation. Contact **CAP** at **1-800-362-1290**.

D. Work and Disability Benefits

The following disability benefit information was adapted from the State Department of Health Services website (http://dhs.wisconsin.gov/Medicaid.htm).

Section 301 – Provision to Continue Receiving SSA Benefits

Section 301 of the Social Security law can be used when a youth, at age 18 years, no longer meets **SSA** medical qualifications. Young adults who receive **SSA** cash benefits and also work can continue to receive **SSI** and **SSDI** benefits as well as **Medicaid** or **Medicare** coverage if:

- they are participating in an approved vocational rehabilitation program prior to age 18 **OR**
- they have an active **IEP**

Ticket to Work

The **Ticket to Work** program is part of Social Security. It is for people who receive **SSDI** or **SSI** benefits because of a disability. It can help those individuals who receive disability benefits and have a work goal. The program offers more choices in getting the services needed to go to work and earn more money. The goal is to earn enough money so Social Security cash benefits are not needed.

Employment, vocational, and other services are available through Employment Networks (private organizations or government agencies). Agencies in the Employment Networks have agreed to work with the **SSA** to provide employment services to beneficiaries with disabilities. A ticket allows the person receiving **SSI** or **SSDI** to choose which of these agencies to work with.

To be eligible for Ticket to Work:

- must be over 18 and under 65
- must have a disability as determined by **SSA** *adult disability standard*.

Work Incentive Planning and Assistance (WIPA)

WIPA is a benefits counseling service that is part of the **Ticket to Work** program. It is available to youth who get **SSA** cash payments and want to work. **WIPA** can help youth understand the impact earning money from work will have on **SSA** cash payments and guidance on how to take advantage of one or more of the many work incentives available to **SSDI** and **SSI** beneficiaries. For individual assessment, contact your local **Community Work Incentive Counselor** (**CWIC**).

Get More Help...

To learn more about the **Section 301 Provision**, visit one of the following websites:
http://www.hrtw.org/healthcare/sect_301.html

To learn more about **Ticket to Work**, visit their website at **http://www.yourtickettowork.com**

To learn more about **WIPA**, visit the website **http://www.eri-wi.org/Benefits/WIPA**

To find a local **CWIC**, visit the website **http://www.eri-wi.org/Benefits/WIPA/WIPAContacts.htm** or call **1-866-968-7842**

E. Medicaid in Wisconsin

The following disability benefit information was adapted from the State Department of Health Services website (http://dhs.wisconsin.gov/medicaid/index.htm).

Wisconsin Medicaid
Young adults with a physical disability, developmental disability, or medical condition that significantly affects daily living or functioning may be eligible for **Medical Assistance** (**MA**). Several **Medicaid** plans are available. Other programs may be available to cover additional expenses or to facilitate service coordination. Some of these plans and programs are:

- **Medicaid**—a plan for people who are age 65 or older, blind or disabled
- **Medicaid Purchase Plan**—health care for people with disabilities who work
- **Family Care—**a long term care program for people who are age 65 or older, or have physical or developmental disabilities
- **Family Care Partnership (Partnership)—**a **Family Care** program that provides a full range of long-term care, health and medical services, and prescription drugs to enable people to live as independently as possible
- **IRIS -** alternative for long term care
- **Community Waivers—**help elderly, blind or disabled people live in their own homes or in the community, rather than a state institution or a nursing home
- **BadgerCare Plus**—a plan for families and children with low income

Some general information about each of these is below, and more detailed information is available online at **http://dhs.wisconsin.gov/medicaid**. There are also plans not listed here, and plan details change from time to time. So it is very important to contact the local county/tribal social or human service agency for complete, current information about plans and eligibility.

Wisconsin **Medicaid** provides coverage for comprehensive medical care to individuals who are over 65 years old, blind, or disabled.

Wisconsin Medicaid eligibility is based on the following:

- must have a disability as determined by the **Disability Determination Bureau** (**DDB**) **OR** be 65 years of age or older
- must be a Wisconsin resident
- must be a US citizen or qualifying immigrant
- must meet the income limits for the program applied for

Wisconsin Medicaid eligibility is automatic for people who qualify for SSI

- in Wisconsin, **SSI** recipients automatically get **Medicaid** coverage

Medicaid Purchase Plan (MAPP)
MAPP can allow individuals to remain eligible for **Medicaid** when they work. **MAPP** has higher asset and income limits than other forms of **Medicaid**. **MAPP** recipients can also save more than the asset limit by using a registered Independence Accounts. Some individuals pay a premium, which is based on the individual's income level.

MAPP eligibility is based on the following:

- must qualify for **Medicaid** based on the eligibility criteria listed above
- be at least 18 years old
- engage in work activity once per month
  OR be enrolled in the **Health and Employment Counseling** (**HEC**) program
- have less than $15,000 in assets

Family Care
Family Care is a long-term care program that serves people with physical and developmental disabilities as well as frail elders. It is not currently available in every county
Family Care has several goals:

- giving people better choices about where they live and what kinds of services and supports they get to meet their needs
- improving access to services
- improving quality through a focus on health and social outcomes
- creating a cost-effective system for the future

Family Care has two major parts:
1. Aging and Disability Resource Centers (**ADRC**s) are a single entry point where older individuals and individuals with disabilities and their families can get information and advice about services and resources in their local communities. **ADRC** services are available to everyone, regardless of eligibility for **Family Care** or **Medicaid** programs.
2. Managed Care Organizations (**MCO**s) manage and deliver the new **Family Care** benefit.

Services are based on each person's needs and preferences.

Family Care eligibility is based on the following:

- must have long-term care service needs
- must be an older adult or an adult with a developmental or physical disability
- must live in a county that is offering **Family Care**
- must meet financial eligibility requirements

Family Care Partnership (Partnership)

Partnership is a **Family Care** program that provides a full range of long-term care, health and medical services, and prescription drugs to enable people to live as independently as possible. Long-term care is any service or support that individuals may need as a result of a disability, getting older, or having a chronic illness that limits the ability to do the things that they need to do throughout the course of the day. This includes things such as bathing, getting dressed, making meals, going to work, paying bills, and much more. There are a variety of services and supports available in **Partnership** that can help people do these things independently or with the support of someone else.

Partnership also covers health and medical services, which includes the services of a physician, nurse practitioner, physician assistant, or other qualified medical professional. Health promotion, disease prevention, health maintenance, and patient education are also provided. In addition, **Medicaid** and **Medicare** drug services are all provided by the Family Care **Partnership** organization. Members do not need to have a separate Medicare Part D drug plan. By coordinating long-term care, health, medical care, and prescription drugs all together, this program is convenient and efficient for its participants.

IRIS is a Wisconsin program where you self-direct your publicly funded, community-based, long-term care supports and services. If an individual qualifies for long -term care in Wisconsin, and if Family Care is available, then the individual can choose whether to have Family Care or **IRIS.** In **IRIS** you use your own natural supports and creativity with your budget to achieve your hopes and dreams.

Get More Help...

Medicaid plans and programs
Plan and program details are available at **http://dhs.wisconsin.gov/medicaid**
Apply for **Medicaid** at the local county or tribal human service agency or online at **https://access.wisconsin.gov/access/**

Family Care resources
Detailed overview of **Family Care** available at **http://dhs.wisconsin.gov/LTCare/INDEX.HTM**
Current county list available at **http://dhs.wisconsin.gov/LTCare/Generalinfo/Where.htm**
ADRCs information available at **http://dhs.wisconsin.gov/LTCare/INDEX.HTM**

IRIS: http://dhs.wisconsin.gov/bdds/IRIS/index.htm

Family Care Ombudsman at Disability Rights Wisconsin (DRW)
To assist people with disabilities in the Family Care and Partnership programs, the Legislature has funded a Family Care Ombudsman program for people under age 60.
http://www.disabilityrightswi.org/archives/237

Community Waivers

Waivers are called waivers because the federal government has waived certain **Medicaid** rules. The purpose of all **Community Waivers** is to allow the state to support people in the community instead of in institutions. Programs are administered by county agencies. In Wisconsin, **Community Waivers** are available in counties not yet participating in **Family Care.** In most counties there is a long waiting list for waivers. So it is important to apply as soon as it is apparent these services may be needed. Eligibility is based on functional need for long-term care, low-income and asset financial requirements similar to **Medicaid**.

Brain Injury Waiver (BIW)

This waiver program provides home- and community-based services for people with brain injuries who need significant supports.

BIW eligibility is based in part on the following:

- must be eligible for **Medicaid**
- must meet the state definition of Brain Injury
- must have, as a result of the brain injury, significant physical, cognitive, emotional or behavioral impairments and be eligible to receive post acute rehabilitation services

Community Options Program Waiver (COP-W)

Frail elderly and persons with physical disabilities at risk of entering a nursing home receive funds and assistance to find community services not available through other programs.

COP-W eligibility is based in part on the following:

- must be eligible for **Medicaid**
- must be age 18 and over with a qualifying physical disability determination **OR** must be age 65 and over and with a long-term or irreversible illness or disability that impairs daily functioning

Community Integration Program (CIP IA and CIP IB, and CIP II)

Persons with developmental disabilities who are relocated from state institutional care (**CIP IA** and **CIP IB**) receive funds for community-based services. The **CIP II** waiver provides community services to frail elderly and persons with physical disabilities after a nursing home bed is closed.

CIP IA, IB, or II eligibility is based in part on the following:

- must be eligible for **Medicaid**
- must have developmental disability (**CIP IA** and **CIP IB**) **OR** physical disability (**CIP II**)

BadgerCare Plus in Wisconsin

BadgerCare Plus provides coverage for families and children in Wisconsin with low income. **BadgerCare Plus** is designed for people who do not currently have access to full health insurance coverage. It is not designed to replace private insurance. For that reason, there are specific rules that do not allow most people to drop their private insurance to participate in **BadgerCare Plus**. However, people who are currently insured might still be eligible. Contact your local county or tribal human services agency for complete eligibility details.

BadgerCare Plus is available to the following individuals:

- **all** children (birth to age 19) regardless of income
- pregnant women with family income up to 300% of the **Federal Poverty Level** (**FPL**)
- parents and relatives who care for a child with family income up to 200% of the FPL
- parents whose children are in foster care with family income up to 200% of the FPL
- farmers and other self-employed parents with family income up to 200% of the FPL
- young adults (ages 18 through 20) who are leaving foster care and turn age 18 on or after 01/01/08, regardless of income

BadgerCare Plus eligibility is ALSO based on the following:

- must live in Wisconsin
- must provide proof of citizenship and identity

BadgerCare Plus has two major health insurance plans. The plan you're enrolled in depends on your family's income. Some plans will have spenddowns (deductibles), premiums and copayments.

Get More Help...

Community Waivers:
General community waiver information available at **http://dhs.wisconsin.gov/bdds/waivermanual/waiverch04_08.pdf#page=1**
Brain injury waiver information available at **http://dhs.wisconsin.gov/bdds/brain.htm**
COP information available at **http://dhs.wisconsin.gov/ltc_cop/COP.HTM**
CIP information available at **http://dhs.wisconsin.gov/bdds/cip/index.htm**

Apply for **BadgerCare Plus** online at **https://access.wisconsin.gov**, or contact the local tribal or county human services agency. A local phone directory will provide the contact information for the local human services agency.

The current **FPL** is provided online at **http://aspe.hhs.gov/poverty**

F. Private Health Insurance

The following private health insurance information was adapted from the Pennsylvania Transition Health Care Checklist (http://www.dsf.health.state.pa.us/health/lib/health/familyhealth/hc_checklist_final_july2008.pdf).

Private health insurance is another option for covering health care expenses. Young adults may be able to continue receiving benefits under their family's private health insurance plan, or they may purchase their own private health insurance plan.

Continued benefits under a family's private health insurance plan

Young adults who are covered by their parents' private health insurance may be able to continue that coverage when they turn 18 years old. This depends on the insurance plan. It's important to review insurance policy details closely to learn about the conditions that would allow a child to continue on the family's private health insurance plan.

Adult Disabled Dependent Child

Young adults who are dependent for life, and who are also being financially provided for by their family, may be eligible to continue on their family's' plan. This requires that the young adult was on the family's plan prior to turning 18. It also requires an annual re-certification of the disability and dependent status.

Student Status

Another way young adults can continue to be covered by their parents' private health insurance plan is if they are students. This often requires full-time student status. It also requires providing proof of college class load each semester and annual re-certification.

COBRA - Consolidated Omnibus Budget Reconciliation Act of 1986

Young adults who are exploring private health insurance options should know about **COBRA**. **COBRA** may allow them to continue on their parents' group health insurance plan. Below are some key features of **COBRA**:

- individuals (and their families) have the right to continue health coverage at group rates for at least 18 months when the employee is laid off, resigns, and sometimes when fired
- continued coverage under **COBRA** may cost more, because the employer does not pay a share of the insurance premium, but is less expensive than most individual health plans
- usually applies to group health plans from employers with 20 or more employees

Get More Help...

The Epilepsy Foundation has a good website describing **COBRA** and **HIPAA** at **http://www.epilepsyfoundation.org/living/wellness/insurance/cobra.cfm**

Youth-purchased private health insurance plans
There are several options for buying a private health insurance plan:

- College - student plan
- Employed - group plan
- Self-pay - single plan
- **COBRA** - if leaving a job that paid for your health insurance

HIPAA is important when exploring private insurance options
The Health Insurance Portability and Accountability Act (**HIPAA**) provides rights and protection for people in group health plans, including protection for coverage that limits exclusions for pre-existing conditions. Under HIPAA, states are required to provide people losing group coverage access to individual insurance regardless of their health status as long as they meet certain criteria. This can help adult children who qualify through their parent's group coverage but lose eligibility when they reach the age limit.

HIPAA - The Health Insurance Portability and Accountability Act.

HIPAA can help ensure continued health coverage and can ensure that current health conditions are covered without a pre-existing condition waiting period. Below are some key features of **HIPAA**:

- allows for opportunities to enroll in or purchase group or special health plans
- young adults with disabilities can apply for individual coverage as a "**HIPAA** eligible individual"
- eligible individuals include those who have had insurance for at least 18 months under a group health plan or **COBRA** coverage
- applications must be made within 63 days of losing the group coverage
- proof that the person with a disability had insurance is required in the form of a certificate of coverage for portability that the person who paid the premiums for the insurance requests from their current employer
- the young adult then needs to present this document to his/her new employer or health plan. This will get rid of or reduce the waiting period for pre-existing conditions

G. Assistive Technology

The following assistive technology information was adapted from the Pennsylvania Transition Health Care Checklist (http://www.dsf.health.state.pa.us/health/lib/health/familyhealth/hc_checklist_final_july2008.pdf).

What is assistive technology?

Assistive technology (**AT**) can be any item, piece of equipment, product or system whether acquired commercially, modified or customized that is used to increase, maintain or improve functional capabilities of individuals with disabilities. It can be devices, but it can also include services needed to locate and learn how to use the tools including evaluation, customization, maintenance, repair and training for the user and those who support him or her.

- **Devices for work or school**: Devices or software that enlarge print or read text, voice dictation or word prediction software, portable computer or keyboards, TTY devices, alternative or hands free mouse, alternative keyboards, specialized writing devices, communication devices, computer based drawing and graphic programs, or specialized calculators, probes and measuring devices, adapted tools such as jigs that can help with specific work tasks.
- **Devices for community living**: Changes to a home or vehicle that enable individuals to get around better, such as ramping for access, shower chairs, voice activated light/heat controls, railings in tubs or around toilets, modified faucets, lower counters, lifts, specialized cooking equipment, jigs for job related tasks, visual cueing for doorbells, phones and buzzers, sound or GPS based guidance systems and talking measuring tools.
- **Devices for recreation**: 3-wheeled adult bike, adapted sports equipment including wheel chairs, adapted hand and foot tools for amputees, bi- skis, adapted seating for access to riding activities, adapted grips/ supports for golf clubs, bats or painting/carving tools, verbal or visual prompts for balls, magnifiers or jigs that can hold tools, materials for projects, specialized lighting or any tools that allow participation in recreation activities.

AT in education and work environments

AT must be considered as part of the **IEP** process for students in the K-12 school system because of federal and state requirements (**IDEA**). Once young adults leave high school, **AT** is included in the **Americans with Disability Act** (**ADA**) legislation for post-secondary school and work environments. However, young adults who are finished with high school and need **AT** have the responsibility to request and learn to use the **AT** themselves. All public colleges and many private colleges and technical colleges have a department to address and support the needs of students with disabilities. These departments may be a good resource for **AT** tools needed for college classes. Other resources for help may include the **Division of Vocational Rehabilitation** (**DVR**), employers, or the Internet. If **AT** is needed for employment, the young adult and his or her **DVR** counselor can consider including **AT** in the **Individualized Plan for Employment** (**IPE**).

Learning about AT

Because young adults will be responsible for knowing what **AT** they need and obtaining the devices themselves once they leave high school, exploring the range of tools while in the K-12 school system is a great idea. School districts may have resources related to how to access and use **AT** devices and should consider the following:

- the **IEP** team can borrow equipment from lending libraries available to the school so students can try an item before buying
- the **IEP** team should consider what tools and services students need and help students learn to use them
- the school or regional **Cooperative Educational Service Agency** (**CESA**) may have staff that are knowledgeable about **AT** options and can assist your **IEP** team in planning for students' current and future **AT** needs

Identifying and obtaining AT

Individual user needs should be considered when identifying **AT** options, as well as what the tool needs to do and the places the tool will be used. A process that can help with identifying the **AT** that will be helpful to a user is known as Student / Environment / Task / Tool (**SETT**). This process gives consideration to both the tasks that need to be done and the **environment** in which tasks need to be completed. Once a device is identified, it can be helpful to try it out before making a purchase, especially because some devices are expensive consider the following

- product vendors may offer trial periods with their products to make sure they work, especially expensive items like communication devices and switch arrays
- some insurance companies, **MA,** or **DVR** may be willing to pay for tools, especially while youth are still in high school or if the device will make it possible for a young adult to work
- some funding sources like **MA** limit the frequency of getting new equipment or **AT** devices. **MA** has limits on the amount they will spend on certain devices
- employers may be willing (or sometimes are obligated) to provide assistive technology to employees to comply with **ADA** if the **AT** is considered a reasonable job accommodation
- in some circumstances, helpful technology may be available at no cost, such as free or open source software (text readers, organizers, etc) that is available on the internet.
- unfortunately computers are generally not considered **AT** from most funding sources, other than K-12 schools, despite the wide array of software tools that can support employment and further schooling

Get More Help...

Wisconsin Assistive Technology Initiative (WATI) can help your **IEP** team to learn more about devices and matching tools to your needs. The activities of **WATI** are grouped into four major components: provision of regional and local training; local technical assistance; increased access to resources; and development of a collegial support and technical assistance network of individuals across the state. Visit the **WATI** website online at **http://www.wati.org**

CESA AT services available to the school district may include assessment support, loaning tools, and teamsupport. If the **IEP team** seems unfamiliar or uncomfortable with **AT**, the **CESA** can be a resource. Check the local phone directory or visit **http://dpi.wi.gov/cesa.html**

H. Mental Health Services

The following information on mental health was adapted from the "Do It Yourself Case Management" document (Nancy Marz, Ann Hager and Kathryn Jalas Franke).

Wisconsin has a county-based mental health system, which can vary quite a bit county to county. You need to work with your county for those who cannot afford private mental health care. Applying to your county (or an agency they direct you to), for services is a way for you or your child to be identified as needing services.

Start with a diagnostic evaluation
The key to services, in addition to needing them, is a diagnosis. Get yourself or your child evaluated to determine a diagnosis if you have not done so already

If you or your child has serious and persistent major mental illness, seek out long term case management services through your county's **Community Support Programs (CSPs)**, available in over half of Wisconsin counties.

Another option may be **Comprehensive Community Services (CCS)**, a community mental health program available in a growing number of counties, providing psychosocial rehabilitation services across all ages to individuals who need more than traditional outpatient services but less than **CSP**, i.e. ongoing high or low intensity need for comprehensive services for those with either a mental health or substance abuse diagnosis.

You or your child's therapist, psychiatrist, teacher, or social worker can make a referral to any program that looks appropriate for you. In a few locations, there are **CSP** programs that accept adolescents that can be very helpful. There is no state-mandated minimum age requirement to be part of a **CSP** – you can try for pre-eighteen admissions or at least placement on a waiting list.

Get More Help......

Additional Resources on Mental Health Services:
Wisconsin Family Ties is a statewide not-for-profit organization run by families for families that include children and adolescents who have emotional, behavioral, mental, and substance abuse disorders.
http://www.wifamilyties.org/

Comprehensive Community Services:
http://dhs.wisconsin.gov/MH_BCMH/CCS/ccsaproved.htm

For Wisconsin organizations visit this web site:
http://mentalhealth.samhsa.gov/publications/allpubs/stateresourceguides/Wisconsin01.asp

For consumer, family, agencies nationally visit this web site:
http://mentalhealth.samhsa.gov/databases/MHDR.aspx?D1=WI&Type=MDR

Additional Resources

Advocacy and Resource Organizations

ABC for Health is a public interest law firm connecting Wisconsin families to health care.
http://www.safetyweb.org

Disability Rights Wisconsin helps people across Wisconsin gain access to services and opportunity through its advocacy and legal expertise. **http://www.disabilityrightswi.org/**

Family Voices of Wisconsin strongly believes in the strength of parent/provider partnerships and works to advance the knowledge and skills of families as they navigate health care and community supports for children and youth with disabilities and/or special health care needs.
http://www.wfv.org/fv/index.html

National Center for Youth Law works to ensure that low-income children have the resources, support, and opportunities they need for a healthy and productive future.
http://www.youthlaw.org

The **Waisman Center** supports the full inclusion and self-determination of people with developmental disabilities and their families. The Center accomplishes this mission through its research and preservice training programs, clinical and intervention services, continuing education programs, and consultation and technical assistance and consultation services.
http://www.waisman.wisc.edu/

Wisconsin Board for People with Developmental Disabilities (WBPDD) helps people with developmental disabilities become independent, productive, and included in all facets of community life. **http://www.wcdd.org/**

WI FACETS is a nonprofit organization that provides training, information and referral, and individual assistance related to special education and **IEP**s. **http://www.wifacets.org**

Wisconsin Family Ties is a statewide not-for-profit organization run by families for families that include children and adolescents who have emotional, behavioral, mental, and substance abuse disorders. **http://www.wifamilyties.org/**

Wisconsin Guardianship Support Center, is part of the Coalition of Wisconsin Aging Groups, and answers questions about the law in Wisconsin relating to guardianships, protective placements, conservatorships, Powers of Attorney for Health Care, Living Wills, DNR orders and Powers of Attorney for Finances.
http://cwag.org/legal/guardian-support

State Agencies and Programs

Wisconsin Department of Health Services (DHS)
Within this Department there are several programs which support individuals with long-term care needs. For a complete list of benefits available to Wisconsin residents who have a disability and/or mental health needs, visit the DHS website at **http://dhs.wisconsin.gov/ddb/index.htm**

Children and Youth with Special Health Care Needs Program

Wisconsin has five **Regional Centers for Children and Youth with Special Health Care Needs** that will assist callers with questions and resources.
http://dhs.wisconsin.gov/health/children

First Step is a 24-hour public health information and referral hotline for children and adolescents age birth to age 21 with special needs. WI First Step serves families and professionals.
800-642-7837 (toll free); online resource database at **http://www.mch-hotlines.org**

Great Lakes Intertribal Council's Children and Youth with Special Health Care Needs Project provides information, resources and assistance to Native American families of children with special needs. **http://www.glitc.org/web-content/pages/cwshcnp.html**

Medical Assistance

ACCESS
ACCESS is a quick and easy way for people in Wisconsin to get answers to questions about health and nutrition programs. Apply for **Medicaid** programs online at **https://access.wisconsin.gov/access,** or contact the local tribal or county human services agency. A local phone directory will provide the contact information for the local human services agency.

Aging and Disability Resource Centers (ADRCs)
ADRCs are service centers that provide a place for the public to get accurate, unbiased information on all aspects of life related to aging or adult living with a disability. **http://dhs.wisconsin.gov/ltcare/Generalinfo/RCs.htm**

Community Waivers:
General community waiver information available at **http://dhs.wisconsin.gov/bdds/waivermanual/waiverch04_08.pdf#page=1**

Family Care is an adult long-term care program in many Wisconsin counties. **http://dhs.wisconsin.gov/LTCare/INDEX.HTM**
Current county list available at **http://dhs.wisconsin.gov/LTCare/Generalinfo/Where.htm**

IRIS is a long-term care option for Wisconsin elders, adults with physical disabilities and adults with developmental disabilities who are **Medicaid** eligible.

Medicaid Plan and program details are available at **http://dhs.wisconsin.gov/medicaid**

Wisconsin Department of Public Instruction
Within this Department, the Division for Learning Support: Equity and Advocacy addresses the needs of students with special education needs through the following:
Special Education Team, Student Services, Prevention, and Wellness Team, Wisconsin Educational Services Program for the Deaf and Hard of Hearing, Delavan, and Wisconsin Center for the Blind and Visually Impaired, Janesville. **http://dpi.wi.gov/dlsea/index.html**

Each **Cooperative Educational Service Agency (CESAs)** has a designated transition coordinator who works with every school district in its area. **http://dpi.wi.gov/cesa.html.**

Transition Advisory Councils (**TAC**) work with school districts and community agencies to promote transition services in the local area. On the **WSTI** web site, use the "Resource Directory" link for your county. There you can find someone to contact in your county who can answer your questions and get you involved in your local **TAC**.

Wisconsin Assistive Technology Initiative (**WATI**) can help your **IEP** team to learn more about devices and matching tools to your needs. **http://www.wati.org**

The **Wisconsin Statewide Parent-Educator Initiative (WSPEI)** is a service for parents, educators, and others interested in parent-educator partnerships for children with disabilities. **http://dpi.wi.gov/sped/parent.html**

The **Wisconsin Statewide Transition Initiative (WSTI)**, the Community of Practice on Transition along with local school districts, county social or human service agencies and the medical community offer support for students and their families to ensure that the transition from high school to adult life is made smoothly. **http://www.wsti.org/**

Wisconsin Department of Workforce Development

The **Wisconsin Department of Workforce Development (DWD)** is a state agency charged with building and strengthening Wisconsin's workforce, include providing job services, training and employment assistance to people looking for work.

Division of Vocational Rehabilitation (DVR)

DVR has embraced the concept of teaming as a way for all staff to work together toward common goals and to achieve the mission: To obtain, maintain and improve employment for people with disabilities by working with Vocational Rehabilitation consumers, employers and other partners. A local **DVR** office can be located by calling **1-800-442-3477** or visiting the **DVR** website at **http://www.dwd.state.wi.us/dvr**. A counselor can explain eligibility and how to apply

Client Assistance Program (CAP)

The **Client Assistance Program** (**CAP**) can help young adults understand their rights and the policies of **DVR**. Young adults can appeal to **CAP** if they disagree with a decision made by their counselor. **CAP** also offers mediation. Contact **CAP** at **1-800-362-1290 or http://dwd.wisconsin.gov/dvr/cap.htm**

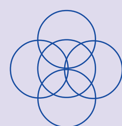
Wisconsin Interagency Agreement and Transition Action Guide for Post-School

The purpose of this DPI/DVR/DHS Interagency Agreement is to fulfill the interagency agreement mandates found in the Individuals with Disabilities Education Act and the Rehabilitation Act and to coordinate services for individuals transitioning from education to employment.
http://www.wsti.org/transition_topics.php

Glossary of Abbreviations and Acronyms

ADA	Americans with Disabilities Act
ADRC	Aging and Disability Resource Center
AT	Assistive Technology
BIW	Brain Injury Waiver
CCS	Comprehensive Community Services
CESA	Cooperative Educational Service Agency
CAP	Client Assistance Program
CIP	Community Integration Program
CM	Care Manager (also referred to as support and service coordinator, or case manager)
CMO	Care Management Organization (a term often used to describe a Managed Care Organization (**MCO**) in Family Care (**FC**)
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1986
COP	Community Options Program
COP-W	Community Options Program-Waiver
CSP	Community Support Programs
CWIC	Community Work Incentive Counselor
CYSHCN	Children and Youth with Special Health Care Needs
DDB	Disability Determination Bureau
DHS	Department of Health Services
DNR	Do-Not-Resuscitate order
DPI	Department of Public Instruction
DVR	Division of Vocational Rehabilitation
FC	Family Care
FCP	Family Care Partnership
FPL	Federal Poverty Level
HCPOA	Health Care Power of Attorney
HIPAA	The Health Insurance Portability and Accountability Act
HRTW	Healthy and Ready to Work
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IM	Income Maintenance (also referred to as Economic Support (ES))
IPE	Individual Plan for Employment
IRIS	Include, Respect, I Self-Direct
ISP	Individualized Service Plan
LEA	Local Education Agency
MA	Medical Assistance (also referred to as **Medicaid** and Title 19)
MAPP	Medical Assistance Purchase Plan
MCO	Managed Care Organization (see also **CMO**)
OC	Options Counselor (may also be referred to as an Enrollment Counselor)
ORCD	Office for Resource Center Development
PACE	Program of All-Inclusive Care for the Elderly
PASS	Plan to Achieve Self Support

SDS	Self-Directed Support(s)
SETT	Student / Environment / Task / Tool Process
SSA	Social Security Administration
SSDAC	Social Security Benefits as a Disabled Adult Child
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TAC	Transition Advisory Council
WATI	Wisconsin Assistive Technology Initiative
WSTI	Wisconsin Statewide Transition Initiative



Waisman Center
University of Wisconsin–Madison
University Center for Excellence in Developmental Disabilities