This rule was filed as 7 NMAC 26.7.

TITLE 7 HEALTH
CHAPTER 26 DEVELOPMENTAL DISABILITIES
PART 7 (APPENDIX A) INDIVIDUAL TRANSITION PLANNING PROCESS

7.26.7.1 ISSUING AGENCY: Department of Health, Developmental Disabilities Division, 1190 Saint Francis Drive Post Office Box 26110 Santa Fe, New Mexico 87502-6110, Telephone No. (505)827-2574
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.2 SCOPE:

A. The regulations provide a systematic process for the individualized planning and implementation of a developmentally disabled resident's transition from the two large, state-operated institutional facilities into a community setting.

B. The ITP process described in this document is intended to develop a proposed community placement for an individual based upon the individual's preferences and upon community service provider selections made generally by the individual's parent/guardian in consultation with the individual. As specified in Activity 19, below, the placement proposal developed by this process is subject to the department of health review of the cost of the individual's plan and/or aggregate costs.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.3 STATUTORY AUTHORITY: Section 9-7-6 NMSA 1978.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.4 DURATION: Permanent.
[01/15/97; Recompiled 10/31/01]

7.26.7.5 EFFECTIVE DATE: January 15, 1997, unless a later date is cited at the end of a Section or Paragraph.
[04/29/94; 01/15/97; Recompiled 10/31/01]
[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.26.7.6 OBJECTIVE:

A. These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in *Jackson, et al, v. Fort Stanton*, et al., N.M. Dist. Ct. No. Civ. No. 87-839. The transition process appearing in these regulations has evolved over time, initially appearing as Appendix A to the Jackson Management Manual. This transition planning process history accounts for the continuing reference in the regulation title to Appendix A. The regulations embody certain agreements and arrangements reached by the parties to the *Jackson* lawsuit. And they reflect the developmental disabilities division's cumulative experience in planning and administering the transition process.

B. Notice of public hearing on the proposed regulations was given in accordance with Section 9-7-6 NMSA 1978. On January 24, 1994, a public hearing was held in Santa Fe, New Mexico. Both written and oral testimony was accepted from all persons who desired to testify. Although limited, the testimony urged the department's adoption of the proposed regulations. The hearing officer made his report thereon, recommending adoption of these regulations.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.7 DEFINITIONS: The transition interdisciplinary team:

A. The Individual: The individual with a developmental disability must participate to the greatest extent possible. There must be a serious effort to ensure that the individual is present and that he or she, even when lacking verbal skills, is given the opportunity to express his or her interests, choices and strengths. However, no individual shall be compelled to participate in the planning process. The individual's normal daily routine and schedule should be followed as much as possible on days when meetings occur; special accommodations for the individual should be identified prior to each meeting and appropriate adjustments and modifications in the meeting

should be planned to enable her or him to participate as fully as possible. An individual may choose someone to represent him/her consistent with his/her wishes in the TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

B. The Parent/guardian: As used in these procedures, the phrase "parent/guardian" shall mean the individual's legal guardian or, if the individual is a minor, the individual's parent(s). The division shall attempt to inform and involve the parent/guardian in the transition planning process, including making reasonable scheduling accommodations and providing interpreters as necessary.

C. The Helper: The helper is someone who knows the individual's capabilities, interests, likes and dislikes and who communicates with the individual. The helper may be a friend, roommate, family member, teacher, co-worker, current or former employee of the institutional facility, foster grandparent, or any other person from the individual's circle of relatives, friends, or acquaintances.

D. The Social worker: The social worker should be the social worker at the facility, i.e., either Los Lunas or Fort Stanton, who has worked with the individual or, if unavailable, the social worker who has been assigned.

E. Facility interdisciplinary team (IDT) members: Facility interdisciplinary team members, designated pursuant to division *Jackson* office policy memoranda, who have been trained to participate in the transition process and who have knowledge of the individual shall assist with ITP planning, implementation and follow-up, as required.

F. Jackson transition representative (JTR): The *Jackson* transition representative (JTR) is the division's representative at transition meetings and activities.

G. Key community service providers: Key community service providers are selected prior to the TIDT meeting pursuant to Activity 7. The term key community service providers means the community residential provider and other providers of significant services for the individual, including but not limited to the competitive and supportive employment provider, medical professional(s) if the individual's medical condition so requires, and other support service providers identified by the expanded IDT as key community service providers. When the individual is of school age, a representative of the local education agency is a key community service provider.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.8 INTRODUCTION:

A. There are two planning components that must be accomplished concurrently:

(1) planning and effecting the move for each individual who will be moving; and

(2) planning and preparing the system of community supports.

B. This document provides the process by which each individual transition plan (ITP) shall be developed. The *Jackson* systemic plan and *Jackson* management manual address the preparation of the system of community placements and supports. These documents have been developed so that the systemic components are consistent with and support the proposed means of individualized planning and placement.

C. The developmental disabilities division, hereinafter "division", is committed to preparing and implementing ITPs expeditiously, consistent with professional judgement. The ITP process reflects the fact that New Mexico is currently seeking to create a system of supports and services for individuals who are moving from institutional facilities to community living. The division anticipates that as its service system for individuals with developmental disabilities expands, the time associated with several activities may be shortened. Therefore, prior to October 1, 1994, the division shall review its experience in implementing these procedures to determine whether any of the provisions may be modified and particularly whether any of the time periods should be shortened. These procedures shall remain in effect unless modified by the division after consultation with the parties in *Jackson et al. v. Fort Stanton et al.,* Civ. No. 87-839 JP. The department of health, hereinafter, "the department", intends that the procedures described herein shall be consistent with federal regulations and requirements. If there is a conflict between these procedures and the federal regulations and requirements, the federal regulations and requirements shall govern.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.9 BASIC CONCEPTS AND ITP DEVELOPMENT GUIDELINES:

A. Individual transition planning is founded on the following basic concepts:

(1) Individual transition planning strives for the goal that the individual can live in and be a part of a community in the same manner and to the same extent as would any other person of like age and interests.

(2) There are no starting assumptions based on models of service. Planning is not performed in order to fit an individual into existing models of service, but rather to tailor necessary supports to the individual who is moving, through uniquely individualized planning.

(3) Supports and services are provided to the extent there is a demonstrated individual need, and no more.

(4) All persons have strengths and interests and are capable of growth and development, at differing paces.

(5) Successful human planning starts from and builds on individual strengths and interests, not deficits.

(6) Human planning must be flexible and responsive to changing individual circumstances and environments.

B. The TIDT shall develop the ITP in accordance with the following guidelines:

(1) The contents of the ITP are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(2) The ITP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable of communicating any preference.

(3) The ITP is designed to utilize services that allow the individual to be more, rather than less, integrated in the community and rely on available generic services to the extent feasible and consistent with the individual's needs.

(4) The ITP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

(5) The ITP can be practicably implemented.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.10 THE INTERDISCIPLINARY TEAM: Each individual residing at Los Lunas or Fort Stanton hospital and training school has an interdisciplinary team (IDT), which is responsible for developing the individual program plan (IPP) as long as the individual resides in the facility. It is the individual's IDT that, among its other activities, has the responsibility for recommending the individual for community placement. Once that recommendation is made, transition planning is begun. To successfully accomplish the development of an ITP, each individual's IDT shall expand to include community membership and become the transition interdisciplinary team (TIDT).

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.11 THE TRANSITION INTERDISCIPLINARY TEAM (TIDT):

A. In order to develop a transition plan that is tailored to the individual, and in order to help achieve successful placement of the individual in the community, the IDT shall expand to include a number of non-professionals, managers and prospective community service providers, as well as the IDT's professionals. There is no universal combination of persons necessary for the TIDT meeting. The individual's participation at the TIDT meeting is necessary unless the individual objects. The participation of the parent/guardian at the meeting is usually required unless the absence is by choice or by necessity. The persons who comprise the TIDT shall normally be present at the TIDT meeting, but in the absence of any person, the team members may proceed with the individual planning process if those present determine it to be appropriate under the circumstances.

B. The TIDT shall usually include the following persons:

(1) The Individual: The individual with a developmental disability must participate to the greatest extent possible. There must be a serious effort to ensure that the individual is present and that he or she, even when lacking verbal skills, is given the opportunity to express his or her interests, choices and strengths. However, no individual shall be compelled to participate in the planning process. The individual's normal daily routine and schedule should be followed as much as possible on days when meetings occur; special accommodations for the individual should be identified prior to each meeting and appropriate adjustments and modifications in the meeting should be planned to enable her or him to participate as fully as possible. An individual may choose someone to represent him/her consistent with his/her wishes in the TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

(2) The Parent/guardian:

(a) The division shall attempt to inform and involve the parent/guardian in the transition planning process, including making reasonable scheduling accommodations and providing interpreters as necessary.

(b) If by 30 days prior to the transition interdisciplinary team (TIDT) meeting described in Activity 11 a parent/guardian has advised the division that the guardian is unwilling or unable to be an active participant during the transition planning process, the division shall seek prompt modification of the guardianship and, if needed, appointment of a co-guardian or a successor guardian to ensure that the individual's guardian, if any, is an informed and active participant in the planning process. A parent/guardian may choose someone to represent him/her consistent with his/her wishes in TIDT meetings. If such a representative is chosen, that person shall receive all notices and other documents sent to TIDT participants.

(3) The Helper:

(a) The role of the helper is to assist the individual in participating in the transition planning process by helping the individual to communicate his or her interests, likes and dislikes to other TIDT members. The same helper should be available throughout the transition process. Whenever the helper is a facility employee, accommodation should be made to facilitate his/her availability for all meetings.

(b) The individual can select his or her helper. For those individuals who do not select a helper, but do not object to the assistance of a helper, the facility's director of social work shall identify a qualified helper. If necessary, the division shall reimburse the helper for reasonable travel expenses incurred solely to visit the individual at least once before the TIDT meeting and to attend TIDT meeting(s) described in Activity 11.

(4) The Social worker:

(a) The social worker should be the social worker at the facility i.e., either Los Lunas or Fort Stanton, who has worked with the individual or, if unavailable, the social worker who has been assigned.

(b) The social worker shall work with the case manager on behalf of the facility to assist with the proposed transition and any follow-up support as required.

(5) The Case manager:

(a) The case manager should be the individual selected or assigned pursuant to Activity 2.

(b) The case manager shall have a good working knowledge of the available generic and specialized services in the geographic area to which the individual will be moving. The case manager, in addition to the duties described herein and in the *Jackson* Management Manual, shall review the bi-weekly reports of the *Jackson* office on the status of pre-placement activities and monitor ITP implementation at the facility and in the community and shall review the ITP and the community programs identified for the individual immediately prior to the move to ensure the necessary supports and services are in place.

(6) Facility interdisciplinary team (IDT) members: Facility interdisciplinary team members, designated pursuant to division *Jackson* office policy memoranda, who have been trained to participate in the transition process and who have knowledge of the individual shall assist with ITP planning, implementation and follow-up, as required.

(7) *Jackson* transition representative (JTR): The *Jackson* transition representative (JTR) is the division's representative at transition meetings and activities. This individual's primary purpose shall be to assist in identifying community service providers and facilitating and documenting the transition planning process.

(8) Key community service providers: Key community service providers are selected prior to the TIDT meeting pursuant to Activity 7. The term key community service providers means the community residential provider and other providers of significant services for the individual, including but not limited to, the competitive and supportive employment provider, medical professional(s) if the individual's medical condition so requires, and other support service providers identified by the expanded IDT as key community service providers. When the individual is of school age, a representative of the local education agency is a key community service provider, and should be present at transition planning meetings.

C. The individual and or the parent/guardian may invite other individuals to attend TIDT meetings. Parents or family members who are not guardians of an adult individual may be invited, unless the adult individual objects. Voting privileges are limited to TIDT core group members, pursuant to DDD *Jackson* Office Policy Memoranda. Scheduling of the TIDT meeting(s) shall not be delayed for the convenience of these "other individuals" who have been invited to attend, nor rescheduled if such "other individuals" fail to attend.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.12 PREPARATION FOR PARTICIPATION IN TRANSITION PLANNING: In order to prepare team members for participation in the team process, the following activities, as provided in the *Jackson* Systemic Plan and Management Manual should occur:

A. Team members who are staff of the department of health or of the case management agencies providing services on behalf of the State shall be trained in the TIDT process.

B. The case manager and the helper shall meet with and provide assistance to the individual so that the individual understands and is prepared to participate in the TIDT process to the extent possible.

C. The case manager shall meet with the parent/guardian and provide information on the TIDT process.

D. The information developed for the individual and parent/guardian pursuant to the *Jackson* Management Manual shall be provided to the individual and parent/guardian.

E. The department shall provide for an interpreter, if necessary, and for transportation for the parent/guardian to attend team meetings as needed.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.13 THE PROCESS FOR THE DEVELOPMENT OF THE INDIVIDUAL TRANSITION PLAN (ITP) - TIME LINES:

A. The individual transition plan (ITP) process provides timelines by which specific actions are scheduled to occur. Although the department of health intends to accomplish the specified activities within the time lines provided, the quality of individual program planning and the involvement of the individual will not be compromised in order to achieve a specific time line.

B. The department of health shall provide to the plaintiffs and plaintiff-intervenors a "planning initiation schedule" on a quarterly basis that will identify the date by which Activity 11, the TIDT meeting, shall be initiated for each individual on the schedule. The initial transition interdisciplinary team (TIDT) meeting is scheduled by the *Jackson* office of the developmental disabilities division (DDD) upon the recommendation of the facility IDT for community placement. Except as provided herein, effective August 1, 1994 and thereafter, the initial transition interdisciplinary team (TIDT) meeting will be scheduled within sixty days of a community placement recommendation of the facility interdisciplinary team (FIDT). If, as of July 31, 1994, new Los Lunas center for persons with developmental disabilities FIDT community placement recommendations exceed one (1), but do not exceed two (2) per month, the requirement to schedule the TIDT meeting within sixty days is effective September 1, 1994. If, as of July 31, 1994, new Los Lunas hospital and training school FIDT community placement recommendations exceed two (2) per month, the requirement to schedule the TIDT meeting within sixty days is effective October 1, 1994. TIDT dates are fixed and subject to change only on condition of extraordinary circumstances, absence of key team members or due process initiation.

C. The time lines shall be extended only so long as necessary to accommodate:

(1) additional TIDT meetings, as determined by the TIDT under Activity 11 or the case manager under Activity 17;

(2) a pending dispute pursuant to the dispute resolution process (DRP) for individual transition plans [see Activity 18 and 7 NMAC 26.8 [now 7.26.8 NMAC] Dispute Resolution Process (Appendix B)]; or

(3) extraordinary circumstances as determined by:

(a) the case manager under Activities 16 and 17, for example.or

(b) the *Jackson* coordinator as a result of significant changes in an individual's condition or circumstances.

(4) A delay for extraordinary circumstances is subject to review by the TIDT upon the request of the individual, the parent/guardian or their representative.

D. Absent such events, the division shall schedule and accomplish the activities identified below within the following time lines:

(1) TIDT meeting (Activity 11): No more than 228 days prior to placement, and as set by *Jackson* transition office calendar (absent extraordinary circumstances or judicial stay order); updated calendars submitted to the court;

(2) Additional TIDTs (Activity 11): within 21 days of initial TIDT meeting;

(3) Cost proposals (Activity 13 - 14): submitted 30 days after distribution of the ITP; reviewed within 30 days;

(4) ITPQA review meeting (Activity 17): scheduled at the final TIDT meeting; to occur 30 - 45 days prior to placement date.

E. Case manager activities (Activities 2 - 9) may begin as early as 120 days, but no later than 90 days prior to the established initial TIDT meeting date.

F. Interim target time lines are more fully set forth below in the specific paragraph describing the activity. Activities 1 - 10 may begin for each individual at the division's discretion sufficiently in advance of the

planning initiation schedule identified by the division. In no event shall Activity 10 be completed later that [sic] 14 days before each individual's planning initiation date. Unless otherwise specified, days means calendar days.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.14 THE PROCESS FOR THE DEVELOPMENT OF THE INDIVIDUAL TRANSITION PLAN (ITP) - TRANSITION PLANNING ACTIVITIES:

A. Prior to the start of the formal transition process, the facility interdisciplinary team (FIDT) shall convene to conduct the annual IPP meeting. At this facility IDT meeting, the following transition activities shall be conducted:

(1) Review individual for community placement; if appropriate, make formal recommendation for community transition to begin and identify probable geographic area of community move. The individual and parent/guardian(s) shall, in consultation with the FIDT, choose the probable area of relocation.

(a) If a recommendation for community placement is made, the presumption is that the individual shall, if a child, move home with necessary supports, or, if an adult, move to the family's home town or nearby. This presumption may be altered by factors such as individual interest and choice, work interest and opportunities, friendships, families with competing interests, and the potential availability and costs of medical resources and other support services or service providers. The social worker shall notify the *Jackson* office of the facility of the individual's community placement recommendation and probable area of relocation within 5 days.

(b) After notification regarding an individual's probable area of relocation, the *Jackson* office shall add the individual to the transition planning calendar. The *Jackson* transition representative (JTR) shall inform the individual and the individual's parent/guardian of the identity of potential community service providers and the types of services the community service provider offers. The facility social worker and case manager, if already chosen, shall assist the individual and parent/guardian in making the community service provider selection (see Activity 7, below).

(2) Establish goals and objectives in the IPP that will facilitate the individual's transition, if community placement is recommended.

(3) Identify strengths and supports within the ten "life areas" (profile of supports form). Make support descriptions useful.

(4) Access regional office staff for community resource information and liaison. Identify generic resources in the area of relocation that could be utilized by the individual.

B. Transition planning for individuals recommended for community placement shall proceed after the facility IDT meeting with the following activities. Unless the context requires otherwise, activities may occur concurrently.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.15 ACTIVITY 1: SELECTION OF HELPER: At least 90 days before the TIDT meeting identified in Activity 11, the social worker shall contact the individual and, using appropriate communication assistance or aids, explain to the individual his or her right to identify a helper and/or representative to assist in the upcoming TIDT meetings and the right to invite any other person as provided in Section 11 [now 7.26.7.11 NMAC]. The individual may refuse to have the assistance of a helper.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.16 ACTIVITY 2: CASE MANAGER ASSIGNED:

A. For the individual moving to the community the social worker shall, after identification of the probable area of relocation, provide the individual and mail to the parent/guardian a listing of eligible case management agencies that serve the individual's probable area of relocation. The *Jackson* transition representative (JTR) shall also provide the individual and the parent/guardian with the information necessary for them to make an informed selection. The parent/guardian, in consultation with the individual, shall, within 21 days of the date the list was mailed, select a case management agency.

B. The social worker shall confirm, in writing, the selection of the agency with the individual, the agency, the parent/guardian and the case management unit of the community programs bureau of the DDD. The social worker shall identify the date by which a case manager must be assigned. The agency shall assign a case manager by the date contained in the written confirmation, which shall be no later than 90 days prior to the initial TIDT meeting described in Activity 11. The assigned case manager must be located in or close to the probable area of relocation but in no instance more than 150 miles from the probable area of relocation.

C. This activity is to be accomplished concurrently with Activity 7, selection of community service provider(s), whenever possible.

D. If, within 85 days of the established initial TIDT meeting described in Activity 11, the parent/guardian has not consulted with the individual and selected a case management agency, the department shall consult with the individual and make the selection.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.17 ACTIVITY 3: MEETING WITH INDIVIDUAL:

A. The case manager shall meet with and, using appropriate communication assistance or aids and observation, get to know the individual. The case manager and the helper shall meet with and provide assistance to the individual so the individual understands and is prepared to participate in the TIDT process to the extent possible.

B. The case manager shall also explain to the individual and helper the process by which the individual's placement shall be designed and implemented, including the TIDT process for developing a proposed placement, the state's implementation decision described in Activity 19, and the process for resolving disputes. As appropriate, the case manager shall provide a copy of the ITP process, the DRP, and the case manager's phone number and address to the individual prior to or at the first meeting.

C. In addition, the case manager shall explain the selection of community service providers, Activities 6 and 7, and make all effort to encourage and expedite this selection, if it has not already occurred, prior to convening any transition meetings. The case manager shall encourage the individual's preference for living arrangements and housemates.

D. If the individual is not familiar with other persons who are identified as probable housemates, the individual will be offered an opportunity to meet with such persons. The individual shall be given an opportunity to approve or object to any identified housemates. The case manager shall communicate with the individual as frequently as necessary before placement to keep the individual informed and involved in the team process. The case manager shall inform the individual and helper that the individual may invite others to attend the TIDT meetings, and arrange co-scheduling of TIDTs where housemates are agreed to.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.18 ACTIVITY 4: RECORD REVIEW: Specified staff at the facility where the individual resides shall prepare a summary of the individual's record as set forth in the *Jackson* Management Manual, with particular attention to those historic events, medical or otherwise, that may affect community living design. The record summary shall be prepared pursuant to division *Jackson* office policy memoranda. This summary of pertinent historic factors shall be provided to the case manager, social worker and key community service providers.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.19 ACTIVITY 5: MEETING WITH INDIVIDUAL'S PARENT/GUARDIAN:

A. The case manager shall meet with the individual's parent/guardian to explain the case manager's role and the process by which the individual's placement will be designed and implemented, including the TIDT activities for developing a placement plan, the state's implementation decision described in Activity 19, and the process for resolving disputes. In addition, the case manager shall explain the selection of community service providers, Activities 6 and 7, and make all effort to encourage and expedite this selection, if it has not already occurred, prior to convening any transition meetings.

B. The case manager shall solicit any concerns the parent/guardian might have with any aspect of the transition process of eventual placement in the community. The case manager shall carefully consider and attempt to address those concerns and shall endeavor to reassure the parent/guardian of the department's commitment to a successful and appropriate placement.

C. The case manager shall provide a copy of the ITP process (7 NMAC 26.7 [now 7.26.7 NMAC] Individual Transition Planning Process (Appendix A), the Dispute Resolution Process (7 NMAC 26.8 [now 7.26.8 NMAC] Dispute Resolution Process (Appendix B) and the case manager's phone number and address to the parent/guardian prior to or at the first meeting with the parent/guardian. The case manager shall encourage the parent/guardian's full participation in the placement process and arrange for interpreter services by coordinating with the *Jackson* transition representative (JTR) and arrange transportation as needed; which shall be paid for by the division, if needed.

D. The case manager shall communicate with the parent/guardian before placement as frequently as necessary (through meetings whenever practical) to keep the parent/guardian informed and involved in the team

process. The information developed for the individual and parent/guardian pursuant to the *Jackson* Management Manual shall be provided to the individual and parent/guardian.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.20 ACTIVITY 6: DISTRIBUTION OF LIST OF ELIGIBLE COMMUNITY SERVICE PROVIDERS:

A. At the first meeting between the case manager and the individual, and the case manager and the parent/guardian(s), the case manager shall explain the basic community service models, including alternatives to traditional service providers; explain the selection of community service provider(s); and provide the individual and the parent/guardian(s) with a listing of eligible community service provider agencies serving the individual's probable area of relocation. The case manager will encourage a timely selection of community service provider(s).

B. Community service providers could be selected as early as the facility IDT meeting (see above), if the individual and parent/guardian(s) are familiar with community service provider agencies in the area of relocation. Community service providers must be selected no later than 30 days after the parent/guardian(s) initial meeting with the case manager (Activity 5, above). The *Jackson* transition representative (JTR) may supplement the list of eligible community service providers at any time. The *Jackson* transition representative (JTR) shall assist the individual and the parent/guardian with the information necessary for them to make an informed selection. The case manager shall review with the parent/guardian and the individual all possible community service providers in the chosen area of re-location during Activities 3 and 5.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.21 ACTIVITY 7: SELECTION OF COMMUNITY SERVICE PROVIDER(S):

A. The parent/guardian, in consultation with the individual, shall select community service provider(s) to be included in the TIDT and shall notify the case manager of the community service provider selection(s). Community service providers could be selected as early as the facility IDT meeting (see above), if the individual and parent/guardian(s) are familiar with community service provider agencies in the area of relocation. Community service providers must be selected no later than 30 days after the parent/guardian(s) initial meeting with the case manager (Activity 5, above). If the individual's choice of community service provider differs from that of the parent/guardian, the case manager shall arrange for both community service providers to be present at the TIDT meeting if possible. If there is more than one eligible community service provider for a particular service, the parent/guardian may indicate alternate community service provider(s) in order of preference in the event the parent's or guardian's first choice is unavailable to provide the applicable service.

B. The *Jackson* transition representative (JTR) shall confirm community service provider selection within 10 days by contacting the community service provider(s) by telephone and in writing. If the parent/guardian has indicated alternate community service provider(s) in order of preference, the *Jackson* transition representative (JTR) shall document the reason for the unavailability of the higher ranked community service provider before contacting the next ranked provider. If key community service provider(s) are not selected by the parent/guardian and individual, within 49 days of the initial TIDT meeting, the *Jackson* transition representative (JTR) and case manager shall make the selection(s). The *Jackson* transition representative (JTR) shall notify the parent/guardian(s) of the selection, as well as the community service provider(s). Notice of the TIDT meeting as provided in Activity 10 shall be mailed. The TIDT shall review these selection(s) and shall select the non-key provider(s) at its first meeting, if the individual or parent/guardian(s) does not do so.

C. The individual and the parent/guardian should give priority to selecting the community residential provider and other key community service providers within the timelines specified above. The key community service provider(s) shall, either before or at the TIDT meeting, acknowledge that it is able to provide the residential placement or other type of services for which the key service provider(s) shall be brought into the planning process as expeditiously as possible, preferably prior to the TIDT, and shall receive all previous planning and client information.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.22 ACTIVITY 8: WRITTEN INDIVIDUAL PREFERENCE ASSESSMENT: After completing the activities specified above, but at least 26 days before the TIDT meeting described in Activity 11, the case manager shall complete, with the individual and helper, a written assessment of the individual's strengths, interests, likes and dislikes. This assessment shall detail what the individual would like his or her life to be like in the community, including maintaining existing friendships and building new ones, community involvement, employment

for the individual who is an adult, hobbies, leisure activities, and housemates. This assessment and review shall be individualized and rely as much as possible on available community generic resources rather than specialized service models. The case manager will collaborate with the *Jackson* transition representative (JTR) and the facility Q.M.R.P. or social worker to facilitate any co-scheduling of the TIDTs where other class member housemates are identified as a preference.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.23 ACTIVITY 9: WRITTEN COMMUNITY ASSESSMENT: After completing the activities specified above, but at least 26 days before the TIDT meeting described in Activity 11, the case manager shall prepare a written assessment of the resources and services available in the community or relocation. At the TIDT, this assessment shall be reviewed, in light of the individual's preferences, as assessed under Activity 8, and the identification of the individual's strengths and needs during his/her daily activities, as identified at the facility annual IPP meeting.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.24 ACTIVITY 10: TIDT MEETING SCHEDULE, NOTICE, AND AGENDA: The *Jackson* transition representative (JTR), shall schedule the full TIDT meeting, which shall be held as promptly as possible after completion of the activities required by Activities 6 and 7. Notice of the date, time and place of the TIDT meeting shall be sent to all participants at least 10 days prior to the meeting. The notice shall also state that participants are to be prepared to address all issues for the individual to ensure a successful transition into a community setting. If any activities required by Activities 6 and 7 occur in less than the maximum time allotted for them by the activity, the *Jackson* transition representative (JTR) shall, whenever possible, proceed to schedule the next required activity (for example, the TIDT meeting required by Activity 11 will be scheduled as promptly as possible after community service providers are selected under Activity 7).
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.25 ACTIVITY 11: FULL TIDT MEETING TO DEVELOP THE ITP:

A. The purpose of the TIDT meeting is to develop the individual transition plan (ITP). The ITP is the document developed by TIDT participants identifying the proposed steps to be taken before and after placement and until implementation of a new annual community individual service plan (CISP).

B. The team should attempt to identify or develop services that use the same resources that the general population uses. For instance, the team should make attempts to use or adapt for use local adult education resources instead of looking for a way to set up a special adult education program for individuals who are transitioning.

C. Upon failing to find a generic solution or one that might be adapted, the team should match the preferred specialized solution to the individual's needs and not provide additional services if the need cannot be demonstrated. For instance, if an individual needs staff support only to assist in preparing the evening meal, the team should find ways to deliver that service and no more, rather than developing a residential placement that provides 24 hour staff support because that service is available at the facility.

D. In addition, the TIDT should specify the training and other necessary supports for direct care staff persons who would work directly with the individual in the community setting. Therapeutic and behavioral supports should be delivered primarily through direct care staff persons since they are the most consistently present, interact the most with the individual, and thus know the individual best. Therapists and psychologists should design the individual interventions, train staff to carry them out through the course of the normal daily routine, monitor the program implementation and be available to coach staff and solve problems.

E. The team shall identify each activity in objective form with specific assignment of responsibility and timelines for the accomplishment of each transition activity. For example, a home living provider would be responsible for the accomplishment of home living related tasks, a work/education provider for work/education tasks, and the case manager for monitoring service provision and assuring the presence and preparation of community life and professional services tasks.

F. All team members are encouraged to participate in all areas of the team process, not just in their area or expertise, skill or involvement. Decisions should be made by consensus. Where there is disagreement, the team should continue to work towards a solution that all participants can accept. If consensus is not reached, the team shall make decisions by majority rule. A record shall be maintained of team decisions. The result of the team's effort is the ITP proposed to the division for implementation.

G. The TIDT should attempt to complete the preparation of the ITP in one meeting. Additional TIDT meetings should be scheduled only if the first meeting does not resolve significant issues, such as the identity of the community residential provider or the competitive or supported employment provider, major medical resources or safety issues. For some individuals, planning for the move will be complex and lengthy and may require more than one meeting. For others, addressing the basic requirements of home, work/education, community life and necessary supports will be straightforward and less complex. The case manager, with the concurrence of the TIDT, shall specify in writing the issue(s) necessitating the additional meeting, the identity of the person or entity responsible for addressing and resolving the issue prior to the next meeting, and any other relevant information.

H. Each additional TIDT meeting shall be held within 21 days of the preceding TIDT meeting. The case manager shall mail a copy of the written reasons for the additional meeting to the *Jackson* transition representative (JTR) and shall notify TIDT members of specific tasks and the date of the next TIDT meeting. Absent extraordinary circumstances agreed upon by the TIDT, there shall be no more than two (2) additional TIDT meetings.

I. The TIDT meeting shall be chaired by the case manager. The team shall begin by reviewing the previous assessments made pursuant to Activities 8 and 9 and the community service provider selections made pursuant to Activity 7. Issues identified and solutions suggested throughout the meeting shall be compared with the assessments to ensure consistency with the individual's preferences where possible.

J. The TIDT shall review and revise the assessments developed in Activities 8 and 9; describe what life should be like for that individual in that community, starting with a discussion of what life is like for other persons of the individual's age and interests and taking into consideration the assessment developed as a result of Activity 9 above; describe those supports that will be needed by the individual; identify the area's generic resources that will be used to provide those supports, or, if generic resources are not readily available, a consideration of those actions that could be taken to enhance existing generic supports for the individual; describe and justify the use of any specialized community service providers. Specialized providers are to be used only when either no generic supports exist or existing generic supports cannot reasonably be enhanced to meet the needs of the individual.

K. TIDT meeting guidelines and agenda: The TIDT shall develop the ITP in accordance with the following guidelines:

(1) The contents of the ITP are reasonable and appropriate to meet the individual's needs and promote identified strengths and capacities.

(2) The ITP reflects the individual's preferences, to the extent appropriate, unless the individual communicates no preference or is incapable or communicating any preference.

(3) The ITP is designed to utilize services that allow the individual to be more, rather than less, integrated in the community and rely on available generic services to the extent feasible consistent with the individual's needs.

(4) The ITP provides services which are least restrictive, not unduly intrusive and not excessive in light of the individual's needs. The ITP can be practically implemented.

L. Life area planning:

(1) The primary task of the TIDT shall be to discuss all issues to be considered for the individual's transition to succeed. This discussion shall include a review of specific items within each of the following "life areas": home environment, vocational, educational, self-care, communication, leisure/social, community resource use, safety, psychological/behavioral/emotional, and medical/health; as well as other pre-placement planning.

(2) The TIDT should review the existing facility IPP objectives related to each of the above "life areas", and identify which objectives are to be continued during the transition period into the community. The TIDT may develop transition objectives to begin at the facility.

M. Supports needed: For each of the life areas discussed, the following general supports should be identified for each relevant transition objective:

(1) human resources needed (volunteers, family, friends/neighbors, paid staff);

(2) assistive technology and adaptive equipment needs listed;

(3) environmental modifications needed / environmental supports described;

(4) transfer and mobility issues identified;

(5) transportation and community access needs identified;

(6) additional support needs identified.

N. Life area discussion items: Life area discussions items include the following (other transition objectives may need to be developed in specific life areas in order to assure a successful transition):

(1) Home environment:

(a) roommate(s) / housemates desired
(b) location of home identified
(c) type of home preferred
(d) orientation to new home
(e) housing agreements signed, telephone and utilities deposits, and household maintenance
(f) arrangement for furnishings and households items
(g) housekeeping skills training required
(h) food management/ assistance with meals
(i) respite needs (not applicable for individuals living independently)
(j) banking, financial and budget/ money management
(k) transfer of personal belongings and description of actual move
(l) self-management of home and daily routine described

(2) Vocational:
(a) referral to DVR/NMCB completed
(b) type of employment and/or environment preferred
(c) orientation to new work environment
(d) assessments needed, vocational training required and/or training in related skills required

(3) Educational:
(a) type of educational goal desired
(b) alternative community based education
(c) orientation to new school environment

(4) Self-care:
(a) toileting
(b) menses
(c) dental hygiene
(d) bathing, grooming and shaving
(e) dressing and clothing care

(5) Communication:
(a) method or style individual prefers to use
(b) communication strengths maintained in new home and/or communication skills training needed
(c) speech therapy
(d) audiology

(6) Leisure/social:
(a) opportunities to continue with or increase personal support systems and friends
(b) opportunities to continue with or increase identified interests and hobbies
(c) opportunities to continue with or increase family interactions and involvement
(d) current and/or desired pets
(e) sexual education, choices and needs (e.g., relationship or dating skills, AIDS/STD awareness)

(7) Community resource use:
(a) orientation to community and social life, including cultural and ethnic heritages of the community and individual
(b) religious affiliation
(c) access to community resources (shopping, laundry, library, post office, etc)

(8) Safety:
(a) safety and hazard awareness training required in home (use of stoves, heaters; emergency use of telephone; poisons, wiring, fire prevention)
(b) safety and hazard awareness training required in community (street safety, dealing with strangers)
(c) alert devices required in home/community
(d) identification card and/or medical alert bracelet/ necklace
(e) updated medical summary

(9) Psychological/behavioral/emotional:
(a) development of self-advocacy and decision making skills

(b) reinforcers and coping mechanisms identified
(c) psychoactive meds used for emotional or psychiatric purposes
(d) community psychologist/ psychiatrist identified
(e) transition or ongoing counseling needs
(f) behavioral responses to new home
(g) crisis intervention needs anticipated
(h) emergency response anticipated
(i) behavior management plan reviewed

(10) Medical/health:
(a) physical condition identified and medical services or appointments needed
(b) how the individual communicates illness identified
(c) physician identified and medical records transferred
(d) physical and occupational therapies
(e) dental appointments made
(f) pharmacy identified and prescriptions transferred
(g) ophthalmologist
(h) nursing services required
(i) medication/self-administration
(j) emergency medical needs anticipated
(k) hospitalization issues discussed
(l) nutritionist needed, special diet
(m) training needs for community medical personnel

(11) Other pre-placement activities/community IDT planning:
(a) pre-placement visit(s)
(b) cross training activities and community service provider skills development
(c) specific strategies to provide stability to children not moving to a family home
(d) guardianship status reviewed
(e) establish a placement date: The placement date established by the TIDT shall be no later than 228 days after the date of the established initial TIDT meeting.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.26 ACTIVITY 12: DISTRIBUTION OF THE ITP:

A. Within 14 days of the conclusion of the TIDT meeting, the *Jackson* transition representative (JTR) shall produce and distribute the ITP to the case manager, the parent/guardian, the facility *Jackson* office (for distribution to the facility TIDT members), the community service provider(s), advocate (if appropriate), the division *Jackson* office, other agencies mentioned in the ITP, counsel for plaintiffs, counsel for intervenors (when appropriate).

B. The case manager, after receipt of the ITP, shall meet with the individual, the QMRP and the helper, and review the completed ITP and what it means from the individual's perspective. The case manager shall assist the parent/guardian by providing information and answering questions concerning the completed ITP and the DRP process.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.27 ACTIVITY 13: COMMUNITY SERVICE PROVIDER CONTRACTS: No later than 30 days after the distribution of the ITP, each community service provider identified in the ITP shall submit, in writing, to the department of health its cost proposal, including the following information:

A. start up funds required;
B. staff training that will be provided as specified in the ITP, to whom and by when;
C. facility modifications that may be required;
D. provision for administration of medication;
E. any other information as specified by the ITP to be provided in this submission;
F. any other information as specified by the department.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.28 ACTIVITY 14: PROPOSAL REVIEW: The department of health shall review the community service provider's proposal and may discuss or clarify any aspect of the proposal with the community service provider. The cost proposals shall be negotiated and approved, according to agreed upon costs, by the division's community programs bureau. The department shall submit to the community service provider a written notice of the state's intent to fund services for an individual within 30 days of receipt of the community service provider's written proposal. The written notice of intent is not a contract. Unusual costs or specialized services may require an additional two weeks to negotiate and approve. It is incumbent upon the community service providers to submit cost proposals no later than 30 days after the distribution of the ITP.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.29 ACTIVITY 15: COMMUNITY SERVICE PROVIDER / STATE AGREEMENT: Unless delayed because of extraordinary circumstances or an administrative (DRP) or judicial stay order, within 30 days of the community service provider's submittal described in Activity 13 above, providers of service and the department of health shall negotiate and execute agreements for the delivery of services as specified in the ITP. The medicaid waiver plan of care (POC) shall be approved and submitted to the case manager for signatures. The case manager shall obtain signatures on the completed plan of care, based upon the approved department cost proposals, at the ITP quality assurance review meeting (Activity 17, below).
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.30 ACTIVITY 16: ALTERNATE COMMUNITY SERVICE PROVIDER SELECTION:

A. An ITP quality assurance review meeting shall be held within 30 - 45 days prior to the placement date specified in the ITP. The purpose of this meeting is to assure that the ITP is being successfully implemented, assigned responsibilities have been or are being met and that activities are appropriately accomplished in preparation for the community placement. Participants at the ITPQA review meeting are the same TIDT members, including designated representatives, who were responsible for the development of the ITP. The *Jackson* transition representative (JTR) is responsible for documenting activities at this meeting. Activities occurring at this meeting include:

(1) review of ITP objectives that occur prior to placement and their implementation status;

(2) confirm accomplishment and/or initiation of tasks by TIDT members;

(3) amendments to the ITP, if required, due to failure to implement objectives or a change in the individual's circumstances;

(4) confirm identity of housemates, staff and others;

(5) confirm cross-over training agenda, participants and schedule with the facility;

(6) describe and plan activities of the actual transition day, including responsible parties and times;

(7) recommend a change in placement date, if required, to assure a successful transition;

(8) finalization of the waiver plan of care: The case manager shall obtain signatures on the completed approved plan of care, based upon the approved cost proposals.

B. The TIDT may review the placement date and recommend a change or extension beyond the 228 day placement requirement; however, changing the originally established placement date requires authorization of the *Jackson* coordinator. Such authorization shall only be given upon evidence of extraordinary circumstances, a judicial stay order or other due process activity.

C. Within 2 working days following the ITPQA review meeting, the case manager shall submit the completed plan of care with original signatures to the community programs bureau (CPB).

D. In addition to the regularly scheduled ITPQA review meeting, described above, the case manager may, in extraordinary circumstances, reconvene the TIDT, in person or by teleconference if planning activity time lines fall behind schedule, the implementation of the ITP is in jeopardy, or the ITP requires significant modification, such as substitution of a key community service provider. In the case of such reconvened TIDT meetings, the assigned *Jackson* transition representative (JTR) will not attend the meeting, and the case manager shall be responsible for documenting the amendments to the ITP that are developed. Amendments should be distributed, in a hand-written form, to all TIDT members and designated representatives at the conclusion of the meeting, if xerox capabilities are available.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.31 ACTIVITY 18 [now 7.26.8 NMAC]**: DISPUTES:** See: Appendix B, Dispute Resolution Process (DRP) for Individual Transition Plans.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.32 ACTIVITY 19: IMPLEMENTATION DECISION BY DEPARTMENT OF HEALTH:

A. Within 7 days of the completion of the DRP, if any, the department of health shall inform the parties to the DRP in writing whether, on the basis of the cost of the individual's ITP or the aggregate costs of individual ITPs, or because the department of health believes the ITP fails to satisfy constitutional or statutory requirement, it is unable to implement the ITP. If the decision was based on cost, the department shall not implement the ITP until and unless they have sufficient funds to do so. The department has the sole discretion to determine whether there are sufficient funds available to implement an ITP. The decision of the department as to the allocation of funds to ITPs is final and not reviewable. The department shall engage in good faith efforts to seek the necessary funds through the supplemental and regular budgetary process for the developmental disabilities division of the department of health and the medicaid DD waiver program and through federal funding which might be available to these programs. Upon appropriation of funding determined by the department to be sufficient, the TIDT or the community IDT, as appropriate, shall convene to review the final ITP in light of the individual's current circumstances and determine whether any changes should be made.

B. In the event the ITP is not implemented because of cost or because the department believes the ITP fails to satisfy constitutional or statutory requirements, within 14 days of the completion of the DRP, the department (with the assistance of its qualified professionals) shall prepare and mail to everyone specified in Activity 12, an interim plan which can be implemented immediately within available resources and which meets constitutional and statutory requirements; or the department shall immediately request the reconvening of the TIDT and direct the team to develop an interim plan which can be implemented immediately. The interim plan shall be distributed within 14 days of its completion by the reconvened TIDT. Any party eligible to initiate a DRP of the original ITP may initiate a DRP of the interim plan pursuant to section IV(E) of the DRP. However, the department's decision regarding the allocation of resources to any ITP or interim plan is within the department's sole discretion and is not reviewable in the DRP process.

C. If within 20 days of mailing the interim plan no party challenges the plan in a DRP, and the department approves, the interim plan shall be implemented forthwith.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.33 ACTIVITIES 20 - 23: Activities 20 - 23 shall take place in the time frame specified unless delayed because of the DRP, or extraordinary circumstances.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.34 ACTIVITY 20: IMPLEMENTING THE ITP: TIDT members shall carry out their assigned pre-placement responsibilities. The TIDT is responsible for assuring the completion of placement activities and the readiness of the placement unless delayed pursuant to the policies of Appendix B, Section IV.F., Dispute Resolution Process.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.35 ACTIVITY 21 MONITORING IMPLEMENTATION OF THE ITP: The assigned *Jackson* office representative shall check and document progress twice per month beginning sixty (60) days prior to the placement date on fulfillment of responsibilities assigned in the ITP. If the representative learns of serious implementation problems the *Jackson* office shall direct the case manager to reconvene the TIDT, either in person or through teleconference, to correct the problem.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.36 ACTIVITY 22: REPORTING ON IMPLEMENTATION OF THE ITP: Every other week the division's *Jackson* office representative shall send to TIDT members a report on the status of pre-placement activity. The *Jackson* coordinator shall report specifically on the status of all agreements and community service provider plans of care. Any delay in execution of agreements that may affect other time lines or pre-placement activities shall be identified and strategies for specific action developed and implemented.

[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.37 ACTIVITY 23: COMMUNITY PLACEMENT: Pre-placement visits with staff and to the new home and work site shall take place as provided in the ITP. Placement shall be accomplished on the date established by the TIDT consistent with the timelines established in Section 13 [now 7.26.7.13 NMAC] above.
[04/29/94; 01/15/97; Recompiled 10/31/01]

7.26.7.38 TRANSITION ACTIVITIES AFTER PLACEMENT:

A. Absent extraordinary circumstances or an administrative (DRP) or judicial stay order, placement shall occur when planned pre-placement ITP activities have been completed. Moving is a stressful experience for anyone. Change in an individual's environment may result in changes in behavior or the need to make adjustments in program design. Thus, intensive interaction and monitoring shall be necessary immediately following placement. During the two months following placement the following activities shall take place:

(1) Habilitation, treatment and services shall be implemented as provided in the ITP.

(2) During the first week following placement, the case manager shall visit the individual on three of seven calendar days at both the individual's residence and day program with one of the visits occurring in the evening and one occurring on the weekend. The case manager shall observe the implementation of planned services. The case manager, in consultation with the appropriate TIDT member(s) and with the prior approval of the department of health, may make adjustments in the plan that do not alter the extent of the plan or the frequency, duration or scope of services. Any significant adjustments to the ITP shall be made by the community IDT convened by the case manager as provided in paragraph 38.1.7 [now Paragraph (7) of Subsection A of 7.26.7.38 NMAC] below. The case manager shall record the time of the visit, his or her observations regarding program implementation, and adjustments made to the plan, if any.

(3) During the first month following placement, the community service provider(s) specified in the ITP shall perform assessments as identified and scheduled in the ITP. The direct care staff may collect base line data for the assessments.

(4) During the second through the fourth week following placement, the case manager shall visit the individual at least two times per week.

(5) During the second month following placement the case manager shall visit the individual at least weekly, or more often if required, by the team or the circumstances in order to ensure program implementation in the new environment.

(6) Case managers shall comply with all developmental disabilities division reporting requirements relevant to post-placement activities and reporting.

(7) The case manager should convene and chair the first meeting of the individual's new community IDT (CIDT) within 14 days of placement. The CIDT shall normally consist of the individual (and his or her chosen representative, if any), the parent/guardian (and his or her chosen representative, if any), the helper, the case manager, and professional and direct care provider(s). In the absence of any member, the CIDT may proceed with the meeting if appropriate under the circumstances. The team shall meet to:

(a) review program implementation;

(b) provide for any necessary program adjustments;

(c) identify and resolve any problems or potential problems in successful implementation;

(d) determine if assessments are occurring as scheduled pursuant to the ITP; and

(e) schedule the next IDT meeting to develop the community IPP, which shall be developed within 60 days of placement.

(8) The case manager shall convene and chair the second meeting and subsequent meetings of the CIDT to prepare and complete the individual's community individual service plan (ISP). If the current placement plan is an interim plan developed pursuant to activity 19, in the course of developing the individual's ISP the CIDT shall review the original ITP that was not implemented by the department of health (see Activity 19) to determine whether any of the components of the original ITP should be incorporated into the ISP. By agreement of the individual, parent/guardian and department of health or as a result of a decision through a DRP, the ISP shall supersede all previous plans.

(9) Subject to the community DRP and to the principles set forth in Activity 19, the ISP shall be implemented within 60 days following placement. Adjustments to the plan of care or community service provider contracts shall be completed pursuant to the ISP.

B. The goal of the community IDT is to ensure the implementation of the community individual service plan (ISP). In order to do this, the case manager or his or her local representative should visit the individual

as specified in the ISP or as often as necessary, but no less than two times per month, to assure that the plan is being fully implemented and to assist the individual in becoming a part of his or her community.
[04/29/94; 01/15/97; Recompiled 10/31/01]

HISTORY OF 7.26.7 NMAC:
Pre-NMAC History: The material in this part was derived from that previousy filed with the State Records Center: DOH 94-01 (DDD), Appendix A, Individual Transition Planning Process Regulations, 4/29/94.

History of Repealed Material: [RESERVED]