Interactive Roles and Time Lines In Transition Planning

INITIATING THE PROCESS High School Entry – (Age 14 to 16)	years where overlap may occur			
	Age 16 to 17	*Age 17 to 18*	*One year Before Graduation*	*Graduation Year*

Students and/or parents/guardians with support networks, substitute decision maker, teachers, siblings, relatives, friends, advocates, foster parents or group home staff

• become aware of options & planning process • think about potential community experiences, graduation date, adult options • provide information on strengths/ interests/ dreams	• explore residential support services of personal preference or plan to reside in family home • understand the implications of leaving school before completing graduation requirements, or availability of adult supports	• at age 18 a person with disability may contact Employment & Income Assistance for assessment of eligibility • apply for appropriate ID • age 18 may involve move to adult residential facility with support from adult programs (ex: SLP,MH)	• plan for post-secondary education/ training, work/community placement, or vocational/day service • choose supports that match individual preferences/needs or advocate for new/enhanced services	• make informed decisions about - employment - move to post-secondary education/training, work/community opportunities - accessing a variety of supports/services from community based service providers.

School

• appoint case manager for transition planning • co-ordinate initial planning meeting with those closest to student (IEP team) • begin appropriate work/community experiences * • explore potential grad date and senior years programming direction with student, family and IEP team • inform families about adult support options & transition planning process • contact adult program (SLP, MH, VR) where no children's worker involved or co-ordinate contact with children's worker	• co-ordinate annual transition planning meeting • research eligibility criteria for adult programs • initiate referrals to adult programs (SLP, VR, MH) in consultation with parents • include adult worker in IEP/ITP meetings • assist with gathering information regarding supports required at home & in community	• co-ordinate annual transition planning meeting • increase focus of instruction towards priority outcomes for transition • advocate for establishment of community supports for adult life, where none currently exist	• co-ordinate annual transition planning meetings • increase work/community experiences* • ensure curriculum supports a planned move to post secondary education/training • Ensure completion of SLP day services: information gathering and referrals • include assigned adult community worker in planning meetings • identify resources required: work/community	• co-ordinate annual transition planning meeting • include assigned VR community worker in planning meetings and provide with current information • ensure graduation/completion requirements have been met • initiate long-term work/ community experience* • co-ordinate continuity of supports with adult community worker or with work/community representative

* May include ongoing career development, volunteer experiences, exploration of day programming options, exposure to recreational opportunities, transportation training, skills for living in the community with independence etc.

Services for Children

Child and Family Service Agencies* • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements • complete referrals for appropriate adult services in collaboration with the parents • attend school transitional planning meetings *Note: For children in care of child and family services agencies, CFS/legal guardian should be involved in the process whenever a parent would be involved	• complete referrals for appropriate adult services in collaboration with the family • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility • participate in school transitional planning meetings to ensure continuity of planning for services and supports	• continue to plan and make referrals to appropriate adult resources	• a child and family services agency may continue involvement beyond age 18 for children who are permanent wards under the guardianship of the CFS agency, depending on individual circumstances	
Children's Special Services, • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements • complete referrals for appropriate adult services in collaboration with the parents • attend school transitional planning meetings	• complete referrals for appropriate adult services in collaboration with the family • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility • participate in school transitional planning meetings to ensure continuity of planning for services and supports	*In consultation with adult worker* • continue to plan and make referrals for required supports		
Children's Mental Health • inform the family about the transition planning process and discuss potential adult service options (EIA, VR etc.) and eligibility requirements • complete referrals for appropriate adult services in collaboration with the parent/legal guardian • attend school transitional planning meetings	• complete referrals for appropriate adult services in collaboration with the family • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility • participate in school transitional planning meetings to ensure continuity of planning for services and supports	*In consultation with adult worker* • continue to plan and make referrals for required supports		

Services for Adults (Employment and Income Assistance, Supported Living Program, vocational rehabilitation services, mental health services and supports, Home Care Program)

• provide transition team with general information re referral process, eligibility criteria, & adult service options **Home Care Program** • receive referral and conduct assessment to determine eligibility • provide information on adult resources • case co-ordinator collaborates in developing care plan • case co-ordinator arranges services specified in care plan • participate in the facilitation of alternate residential placement in community	**Supported Living Program (SLP)** • acknowledge receipt of referral, check eligibility & assign community worker • community worker participates in planning meetings with transition team (at least one before assuming case responsibility) • provide information on adult supports/service providers • request for funding for residential/support services if required at age 18 • complete referrals to residential service provider of choice as required • provide information for establishment of community supports for adult life, where none currently exist **Day Services** • check eligibility & assign community worker	**Regional Health Authorities (RHA)** **Mental Health (MH) Services and Supports** • check eligibility and assign community worker • assigned worker participates in planning meetings (at least one before assuming case responsibility) • provide information on adult resources • complete referrals to adult resources • request for funding for residential and/or support services if required at age 18 **Home Care Program** • assess and facilitate request for funding for residential/support services if appropriate at age 18	**Employment and Income Assistance** • apply in person at age 18 and beyond **Vocational Rehabilitation Program FSH, RHA, designated agency (SMD, CNIB, CPA)** • acknowledge receipt of referral, check eligibility & assign community worker • community worker participates in meetings with transition team • provide information on adult supports/ service providers • develop individual vocational plan • identify and initiate referral to service provider of choice and request funding for services, including technical assessments, upon student leaving school **Supported Living Program (SLP) – Day Services** • ensure completion of previous steps in the referral process • community worker participates in meetings • request funding for day service resources two years before graduation date • referrals to day service resources and adult clinical services	

Healthy Child Manitoba — Putting children and families first

Manitoba