

**Revised Brant, Haldimand and Norfolk Addendum**  
to the  
**Transition Planning Protocol and Procedures for  
Young People with Developmental Disabilities**

The purpose of this Addendum is to clarify local processes that will support community collaboration in an integrated planning process based on the Hamilton-Niagara Regional Transition Planning Protocol and Procedures for Young People with Developmental Disabilities. The focus of Transition Planning is to move out of children's services at age 18 as well as connection with natural, social and other community services and supports to build interests, skills and independence.

All of the processes are assumed to occur with the consent of the young person and/or their family.

**1. Identification of Youth by Age 14**

- a. MCYS-funded agencies, and other sector organizations including school boards, will refer children/young person who they believe may be eligible for developmental services to Contact Brant/Contact Haldimand-Norfolk at any time before age 18, **ideally before age 14**, to facilitate the start of transition planning. For schools, this should be part of the transition planning to Grade 9.
- b. **Schools** are mandated to ensure students have integrated transitional plans in place as part of the IEP. Integrated transition planning involves principals, teachers, students and their families and others who support the young from community agencies and health care providers.
  - To facilitate integrated planning, schools may invite involved service providers to their school-based transition planning meetings, including the local Contact agency.
  - If a youth identifies to the school that they do not want children's services agencies involved, the school will continue with their IEP process. At least annually, the school should revisit if the young person and family will consent to community agencies involvement.
- c. As soon as possible after a child/young person with a developmental disability has been made a **ward of the Society**, the child welfare worker will call the local Contact agency to register the child/young person. They will advise of any changes/new information (e.g. change of address, eligibility status) as it occurs. On a quarterly basis, the Society will inform the local Contact agency of all those children/young person registered on the provincial TAY database to ensure timely identification.
- d. The **Contact agencies** will confirm potential eligibility for adult developmental services, complete a referral for the young person for transition planning, and inform the young person and their family about transition planning. The Contact agencies will continue to be responsible for providing information about available and appropriate children's services and completing any children's referrals that are identified as appropriate through the Transition Planning process. Contact agencies

are also responsible for managing the children's service resolution process as required.

- e. Rights of **consent and protection of privacy** are paramount; each organization will utilize their internal procedures for consent and sharing of information.
- f. **Annually, the Contact agencies** ensure every potentially eligible youth is flagged for follow-up on transition planning.

## 2. Written Transition Plan

- a. The Contact Agencies and each school's IEP contact will link to begin the integrated transition planning process and ensure consent is addressed; this can be initiated by the school or by the Contact agency.
  - If the young person and family do not want children's services involved, the school will proceed with the IEP process and revisit their involvement at least annually. The school would need to provide the young person and family with information about the DSO application for adult services at age 16, and direct them to their local Contact agency to complete the referral.
  - If the youth is not a student in a publicly funded school, the Contact agencies will facilitate the beginning of integrated transition planning with representation from appropriate children's services and education (e.g., provincial schools, home-schooled, etc.)
- b. Contact agencies will identify current service providers involved and connect with those organizations to identify the need to initiate the integrated transition planning process.
  - If the children's services agencies are not able to proceed with integrated planning at that time, the school will continue with the IEP process and the children's services agencies will join the planning team as soon as resources can be allocated.
- c. The young person and their parents are invited to attend integrated transition planning meetings that will include the appropriate school representative(s) and relevant MCYS funded children's services.
- d. There will be a single integrated transition plan. Each organization may incorporate the written transition plan into their own template (e.g. IEP, Plan of Care, Common Tool for Intake, etc.).
- e. Each written transition plan will **include the key elements** listed on the Transition Plan Checklist (attached).
- f. The lead agency will ensure a copy of the written transition plan is provided to the youth and their parents. A copy of the written Transition Plan will be provided to the local Contact agency whenever updated, and at least annually.
- g. The local **Contact agency** retains primary responsibility for overseeing the Transition Planning process, and storing the most updated Transition Plan for each young person until that individual turns 18.

## 3. Identification of a Lead Agency and Planning Team

- a. The school IEP contact and the local Contact agency are responsible for working together to start the integrated planning process, including identifying members for

the Planning Team for each youth. The Planning Team will usually be **people important to the youth** and/or involved in providing services.

- b. When necessary, usually for youth with more complex needs and/or identified in the priority groups of the Protocol, and when agreed by the young person and family, the Contact agencies will facilitate the establishment of a planning team and identification of a Lead Agency. The Contact agency identifies if the young person is involved with any children's services; is a crown ward and/or; has complex needs.
- c. Children's service providers will prioritize all requests for their involvement in integrated transition plans based on the priority groups.
- d. Current community process to identify the Lead Agency for a young person will be used; usually the Lead will be a children's service agency already providing services including case management/service coordination functions.

Typically the following considerations in determining a Lead Agency will be:

- If the young person is a crown ward, the local child welfare agency will be the Lead or co-Lead;
  - If a single agency is involved, that agency should be the Lead;
  - If multiple agencies are involved, family preference is respected or service providers meet and identify the Lead/Co-Leads;
  - Where the young person is not in service and is waiting for service from an agency, that agency should be the Lead, or service providers meet and identify the Lead.
  - Where the young person is not in service and not waiting for service, the local Contact agency will assume the Lead; the Contact agency will complete an intake which will be used as the written Transition Plan. The Contact agencies will encourage families to call their local Contact for any children's services-related needs, inform them of the importance of planning, and identify the transition planning requirements of schools.
- e. The young person and parents are invited to participate in integrated transition planning process that includes the school's IEP lead and relevant MCYS funded children's services. Planning meetings for the young person that are scheduled for service coordination will be used whenever possible to include coordination of transition planning, rather than establishing a separate process.
  - f. As Lead responsibilities or staff change, transfer to another Lead may be most appropriate; ensure to advise the appropriate Contact agency.

#### **4. Referral to Developmental Services Ontario (DSO) at Age 16**

- a. Referrals to the DSO will be **made by the Contact agencies** at age 16.
- b. All organizations should ensure the young person is not yet referred to the Contact agencies and are given information to connect to the Contacts by age 16 so a referral to the DSO can be completed.
- c. The DSO will determine eligibility for adult developmental services and inform the appropriate Contact agency of the outcome; the Contact agencies will inform those involved in planning for that young person; when there is a Lead Agency identified, the Lead Agency will be informed.

- d. The Contact agencies will send the DSO a copy of the current Transition Plan for each youth once eligibility is determined, and will ensure updated copies are sent when provided to the Contacts.
- e. The DSO will complete their application process including the Application for Developmental Services and Supports (ADSS) and the Supports Intensity Scale (SIS); a copy of the Assessor Summary Report will be sent to the appropriate Contact agency, which will provide a copy to inform those involved in planning for that young person; when there is a Lead Agency identified, the Lead Agency will be provided with the copy.
- f. The DSO cannot facilitate referrals for Ministry-funded adult developmental services and supports until young people are 18 years of age.
- g. Once eligibility is determined, the Contact agencies will specifically inform the DSO of those young people who have been identified as likely to require a continuation of residential services at age 18; the DSO will ensure that these youth are placed on the Pressures List of the local community's Adult Developmental Services so that planning will occur.
- h. Planning by the adult developmental services starts once eligibility has been determined. The Contact organizations will be responsible for developing an aggregate data report for their local Adult Developmental Services planning table for young people aged 12-16 to help inform future planning; the DSO will be responsible for developing an aggregate data report for each community Adult Developmental Services planning table for young people 16 – 18 who have been determined to be eligible for adult developmental services.
- i. Transition Planning will continue in the Children's Services sector while planning is also happening at the Adult Developmental Services Planning Table. A feedback process will ensure Children's Services provide Adult Developmental Services with updates and changes on the circumstances for the young person, and will also ensure Adult Developmental Services provide Children's Services with updates on service availability and considerations.
- j. Planning for adult developmental services will occur by all community organizations with the understanding that funded adult services may not be available for the youth at age 18.
- k. If a young person is deemed ineligible for adult developmental services, the requirement for transition planning within the scope of this Protocol ends; the youth should be directed to the most appropriate service system and to the local Contact agency.

## **5. Transition Planning After Age 18**

- a. When a young person who is eligible for adult developmental services turns 18, the DSO picks up responsibility for monitoring the needs of that individual through their Waitlist and/or Vacancy management process.
- b. At age 18, the young adult ages out of children's services; the young person's file at the local Contact agency is closed and the Children's Services sector Lead Agency ends involvement.
- c. For crown ward young people and young people with complex special needs that likely require residential service at age 18, the planning responsibility transfers to

the local Adult Manager's Table; all other young people are referred/waitlisted and follow the typical DSO process.

- d. The DSO makes referrals/wait lists for adult services at age 18, based on the ADSS/SIS recommendations.
- e. Young people/families call the DSO if needs change after the young adult turns 18.

## **6. Conflict Resolution**

All staff involved in transition planning will attempt to manage conflict as close to its source as possible. Staff from each organization will follow their organization's process and procedures for alerting management about any areas of confusion or conflict.

Front line staff will first attempt to resolve any issues directly with other front line staff, as appropriate. Should these attempts be unsuccessful, front line staff will bring their concerns to the manager/supervisor within their organization(s).

Any concerns regarding the Protocol or Addendum should be identified to the appropriate local Contact agency. The Contact agency may call a meeting of local Brant, Haldimand and Norfolk stakeholders when clarification of the Addendum is required, and will facilitate a regional meeting when clarification of the Protocol is required.

## Transition Plan Checklist

The Transition Planning processes meant to provide young people with developmental disabilities with a smooth transition from childhood to adulthood. The Transition Plan for the young person can be written in a form already used for transition planning, such as a School Board IEP or CAS Service Plan. To meet the requirements of the Transition Planning Protocol, the written Plan will include decisions; identify roles, responsibilities and action plans; anticipate potential issues and develop contingency plans for significant delays in receiving requested services. If you need a copy of the Protocol, please call your local Contact agency. The Plan for the young people will include:

<input type="checkbox"/>	Name of the young person, and parent(s)/guardian(s) as appropriate
<input type="checkbox"/>	Name of contact person writing the plan
<input type="checkbox"/>	Date of Plan / Date of Review
<input type="checkbox"/>	Hopes, dreams, talents, abilities, needs
<input type="checkbox"/>	General and specific goals (where will the youth live; meaningful activities; what will the youth do after graduation, etc.)
<input type="checkbox"/>	Actions to achieve goals
<input type="checkbox"/>	Supports needed to live as independently as possible
<input type="checkbox"/>	List of agencies / services already involved; consideration of the information contained in the youth's Individual Education Plan (IEP)/Plan of Care)/and any other existing plan
<input type="checkbox"/>	Other community supports (family, faith, employment, volunteer, education, recreation)
<input type="checkbox"/>	New agencies/supports/services to explore
<input type="checkbox"/>	Who will do what, and by when
<input type="checkbox"/>	When will the Plan be reviewed
<input type="checkbox"/>	What is the communication plan if there is a problem
<input type="checkbox"/>	Name of the Lead Agency (if applicable; note if this changes)
<input type="checkbox"/>	List of Planning Team Members (if applicable)
<input type="checkbox"/>	Date that the Plan/updated Plan was sent to the local Contact agency (at least once a year)
<b>At age 16</b>	
<input type="checkbox"/>	Call the local Contact agency for referral to Developmental Services Ontario (DSO)
<b>After age 16</b>	
<input type="checkbox"/>	Describe the plan for discharge from children's services
<input type="checkbox"/>	Ensure expectations in the Plan are realistic and based on youth's choices
<input type="checkbox"/>	Include the outcome of DSO eligibility decision
<b>If Young Person is eligible for Adult Developmental Services</b>	
<input type="checkbox"/>	Date the DSO application process scheduled/completed
<input type="checkbox"/>	Include the DSO Assessor Summary Report when it has been sent to the Planning Team
<input type="checkbox"/>	Invite adult service providers to the Planning Team and/or consult with the DSO
<input type="checkbox"/>	Include adult planning feedback to inform the Transition Plan

