



Connecticut DDS Transformational System Plan

Transition Plan Template: Form A2 – Additional Residential Settings

Provider Information 1

Form A2. Additional Residential Settings..... 1

 Section 1. Setting Details 2

Provider Information

All items in this section are required.

1. Agency Name:

2. Primary Region (select one):
 - a. North
 - b. South
 - c. West

3. Contact Information:
 - a. Name:

 - b. Role:

 - c. Email:

 - d. Phone Number:

Form A2. Additional Residential Settings

This Part is intended for use with Part A Residential. If the transition plan only includes one congregate residential setting, just use Part A. If the plan includes transitions from more than one congregate residential setting to more individualized, community-focused supports, please provide information about the settings in the table below. The reference number is only for the purpose of the Transition Plan.



Section 1. Setting Details

Reference Number	Is the setting a CLA or CRS?	Program name and address	# of people currently supported in the program?	# of people anticipated will transition?
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Note: If you require space for more settings, please complete additional copies of this form.

For Regional Review Only

Meets requirements: For each, selected a provided option in the first column and provides context in remaining columns.

Meets requirements

Needs revision

Reviewer notes :