STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
SOCIAL SERVICES
Six Harrington Road
Cranston, RI 02920-3080
TEL: (401) 462-2766
FAX: (401) 462-3204

SLA TRANSFER REQUEST FORM

To be submitted with Current ISP for all DDD Clients Requesting Transfer from Group Care to SLA Placement.

Requested Move Date: _____ **Date of Next ISP Renewal**: _____

Client: _____ **Guardian (if applicable):** _____

Client ID #: _____ **Date of Birth**: _____

SLA Provider Agency: _____ **BHDDH Worker**: _____

Will all ISP goals and currently authorized services be maintained in SLA placement? Yes [ ] No [ ].
If no, please indicate:

New Day Program Agency_____

New Employment Services Agency _____

New Goals_____
_____

Does Client have a behavior plan? Yes [ ] No [ ]. **If yes, has SLA Contractor reviewed it?** Yes [ ] No [ ].
What will SLA provider/contractor do to address behavioral plan?

Does Client have a medical plan? Yes [ ] No [ ]. **If yes, has SLA Contractor reviewed it?** Yes [ ] No [ ].
What will SLA provider/contractor do to address medical plan?

Does Client have accessibility needs? Yes [ ] No [ ].
Please itemize accessibility needs:

_____ _____
Client Signature *SLA Provider Agency Signature*
Date: _____ Date: _____