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AUTHOR   Steveley, Janet D.; Houghton, Joan; Goehl, Karen S.; Bailey,
                Brent R.
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ABSTRACT
                This booklet provides information designed for individuals
who are involved in the transition planning process both for persons with
deaf-blindness and for persons with other disabilities. The purpose of the
guide is to introduce common misperceptions encountered during transition
planning, components of transition planning, and the transition planning
process. The first section of the guide presents common misperceptions based
on the collective experiences of educators who have participated in
transition planning for students over the years. The following section
identifies general considerations and common transition issues when beginning
transition planning, including thinking about the person, exploring all
options, learning to work as a team, and sharing responsibility among team
members. A general step-by-step process to transition planning is then
presented, along with examples of plans developed for two women with vision
and hearing losses who returned home to Indiana after attending schools out
of state. Appendices include resource information, checklists, the transition
plan with a map with timelines for the two women, and a transition mobile
with instructions. A glossary of common terms used during transition planning
is included. (CR)

Planning Today Creating Tomorrow

A Guide to Transition

Janet D. Steveley, MS
and
Joan Houghton, MS
Helen Keller National Center-
Technical Assistance Center

Karen S. Goehl, MS
Indiana Deaf-Blind Services Project

Brent R. Bailey, PhD
Indiana Deaf-Blind Services Project Consultant

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Indiana State University

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Indiana Deaf-Blind Services Project Consultant

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Special thanks to Craig Eberhardt of the Blumberg Center for Interdisciplinary Studies in Special Education at Indiana State University, for the layout and design of this publication.

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Introduction

The word transition has become synonymous with change for many persons with disabilities today. According to data over the last decade from the TRACES Technical Assistance Project, approximately 600 individuals who are deaf-blind reach age 22 each year. They leave traditional educational programs and enter the world of adult services. Though parents, educators, and service agencies have tried to prepare them for the future, the process is anything but simple. In the end, the number of people, procedures, and problems confronted during transition planning continue to make the prospects for a successful outcome extremely challenging.

Planning Today-Creating Tomorrow: A Guide to Transition contains information designed for individuals who are involved in the transition planning process for persons with deaf-blindness including those persons with other disabilities. The purpose of this guide is to introduce common misperceptions encountered during transition planning, components of transition planning, the transition planning process applied to two women who returned home to Indiana, resource information, and transition terms and definitions.

The guide is organized as follows:

A. Common Misperceptions
These misperceptions were based on the collective experiences of the authors who have participated in transition planning for students over the years.

B. The Importance of Sound Transition Planning
This section identifies some general considerations

and common transition issues when beginning transition planning.

C. Sorting It Out
    This section contains a general step-by-step process to transition planning with examples applied for two women who returned home to Indiana.

D. Appendices
    Included in this section are resource information, checklists, the transition plan using a map with timelines for the two women and a transition mobile with instructions.

E. Glossary of Terms
    Provided in this section is a list of common terms along with definitions often used during transition planning.

NOTE.
    It should be noted that each local education agency addresses transition planning differently for students. Some agencies include a statement of transition services and transition related objectives in the student's Individualized Education Program (IEP). Other agencies choose to have a separate transition plan (Individualized Transition Plan) attached to the IEP for the student. Check with your agency to become familiar with the type of plans used for documenting transition related activities.

Common Misperceptions

Misperception #1

The right to quality, community services is guaranteed to every individual with a disability.

Educational programs **are guaranteed** for students. However, community services **are not guaranteed** for adults even though adults may be eligible for services. This means there may be long waiting lists. These waiting lists are due to limited funds or state priorities for moving individuals from institutions to community settings.

Misperception #2

The transition process means getting a job.

A job is important, but other areas need to be considered during the transition process. Some of the areas may include; living arrangements, relationships and friends, leisure time, homemaking, education, health concerns, transportation, estate planning, guardianship, advocacy, and financial needs.

Misperception #3

A good transition plan will guarantee a successful transition from school to adulthood.

The transition plan is an important part of the process. However, making sure goals and objectives are met is what really counts. Too often, transition plans are reviewed at annual IEP meetings only to find that nothing has happened. The transition plan is a useful guide, but it is one very small part of the transition process.

Misperception #4

Team members work well together during the transition process.

Bringing a group of people together does not mean they will automatically work as a team. For example, team members may not understand each others' functions, roles, goals, or terms. Education team members may not be aware that vocational rehabilitation members and services primarily focus on employment and are time limited services. Vocational rehabilitation team members may not be aware that educators should take an active part in job preparation.

Misperception #5

It is easy to make decisions as long as team members keep the person's best interest in mind during the transition process.

Group decision making is not easy because what different team members consider important will depend on personal beliefs, values, and experiences. For example, one team member supports a person's choice to work in the community. Another team member believes that adequate supports are available in a sheltered workshop and not available in the community.

Misperception #6

Choices about services are limited to what is available in the local community.

Often, a person's choices are forgotten when team members choose from existing services without considering new possibilities. For example, all team members agree the person enjoys physical work outdoors in quiet, non-crowded

places. However, the only work option presented at the team meeting is assembly work in a crowded, noisy, sheltered workshop. Team members did not search for other possibilities based on the person's preferences.

Misperception #7

Team members have all the answers to all of the questions that may arise during the transition process.

Meeting a person's needs and preferences means finding people who can help. No one team member can possibly have all the answers to all of the questions. For example, the person's family members are interested in meeting future financial needs through estate planning. Other team members may not have the information, but they can provide resources to the family to get additional information.

Misperception #8

The monies to cover costs of services for adults with disabilities are from one government source.

Funds for adult services come from a variety of sources. Creating a total funding package often is complicated because monies are provided by various government agencies including but not limited to Vocational Rehabilitation, Social Security Administration (SSA), Mental Health, Mental Retardation/Developmental Disabilities (MR/DD), and Housing and Urban Development (HUD). Each funding source has different application processes and eligibility criteria.

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The Importance of Sound Transition Planning

Thinking about the Person

Sound transition planning begins with getting to know the person. Team members will need to learn about the important aspects of the person's life. These aspects may include the important people in his life, what works and does not work for him, how he currently spends time in the community, information regarding his capabilities, and his dreams about the future.

There are a number of ways to gather this information. Home interviews, mapping, and choice/preference surveys are a few of the tools available. Most importantly, team members should carefully listen to the person and those individuals who are closest to him. If he is not able to tell his dreams, his dreams will need to be explained by those members who know him best. See Appendix A for several resources about person-centered planning.

Designing the Future

The transition planning process is simply designing a future lifestyle based on a person's abilities, needs, and choices. This process helps the person decide things like how she will spend time with friends, what work she will do, and where she will live.

Transition planning meetings usually begin by discussing the person's dreams for the future. Once team members have a clear understanding of the person's dreams, they can assist her by writing appropriate IEP goals, and connecting her with needed services and resources. Team members need to

realize that her dreams and goals will change over time. As these dreams and goals change, her plan will need to be updated with her team members. See Appendix B for several resources about transition planning.

Understanding the System

Adult service systems are complex. As the person leaves school, he will require different services. Each of these services are provided by different agencies. For example, if he needs to receive assistance in finding a job, locating a home, and getting financial assistance, he will need to go to three different agencies. Each of these agencies will have different rules about who can receive services. It is important for planning team members to know about state and local service systems.

Some of the ways team members can learn more about service systems include reading brochures and transition materials, or attending training workshops. Inviting adult service representatives to join the team early in the planning process is another way team members can learn more about state and local adult systems.

Exploring all Avenues

Team members need to consider services and resources outside of "disability" agencies. Communities have a number of services available to all citizens. For example, a person, regardless of her disability may qualify for food stamps or low income housing assistance programs.

In order for her to get these services, team members need to learn what is available in her community. Team members may want to gather information about a "non-disability" agency or invite a guest from the agency to the team meeting.

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Learning to Work as a Team

Teamwork means coming together around a common goal, sharing ideas, and solving problems. Working together as an effective team takes time. In the beginning, team members may not know each other, know what each other does, or know each other's views.

Clear goals, roles, and processes will provide structure to help team members move forward. For example, if a team member understands his role within the team, he will be an effective team member. If a team member does not understand his role, he may feel frustrated and not participate during team meetings. See Appendix C for more information on working together as a team.

Sharing Responsibility

Sharing responsibility simply means dividing tasks equally among team members. Some tasks may need to be completed by a particular team member or a subgroup of team members. For example, applying for services through Vocational Rehabilitation is given to a subgroup consisting of the person, a family member, and the vocational rehabilitation counselor. Team members have the opportunity to volunteer for tasks based on their interests, talents, and roles.

One way to help team members share responsibility is to use an action plan. Action plans are written during each meeting. Tasks, timelines, and team members responsible for completing the tasks are written on the plan. At the beginning of the next team meeting, the action plan is reviewed to see what has been done. See Appendices D and E for more information on effective meeting strategies and action plans.

How Does Transition Start?
Beginning the Dialogue

The Individuals with Disabilities Education Act (IDEA) requires school members begin the transition planning process at least by the time the person is 16 years old. The individual responsible for starting the transition planning process usually is the transition coordinator, teacher, or school counselor. This individual sets the date for the meeting, and invites the person, family, and adult agency representatives. During the meeting, this individual guides the discussion, helps organize information, and provides the direction for next steps of the planning process. After the meeting, this individual makes sure all team members receive a copy of the action plan and oversees the progress of team members.

Karen and Bachie are young women from Indiana with vision and hearing losses. Karen attended school at Perkins School for the Blind in Watertown, Massachusetts. Bachie attended school at Chileda Institute in La Crosse, Wisconsin. After completing school, both women planned on returning to Indiana. See Appendix F for Karen and Bachie's Transition Map.

Transition coordinators from Chileda and Perkins talked with each young woman's local school district representative to begin the transition planning process. They asked for help from the Indiana Deaf-Blind Services Project Coordinator. In addition, the newly forming teams asked for help from an associate at the Helen Keller National Center-Technical Assistance Center . . . *The dialogue began* . . .

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Who is on the Team?
Partners in Planning

A team is formed around the preferences and needs of the person and his family. A team usually consists of the person and his family, school staff members, adult service representatives, and other advocates.

The team may include school staff members, such as a vocational educator, a vision teacher, or a transition coordinator. Adult agency representatives may include a case manager, a rehabilitation counselor, or an employment specialist. Advocates might include a neighbor, a co-worker, or a family friend.

Local teams were formed before Karen and Bachie returned to Indiana. Their team members included their school district representatives, case managers from the developmental disabilities agency, their parents, and vocational rehabilitation counselors. The team brought in other people as needed for special information.

A Vision of Tomorrow
A Person-Centered Approach

Future planning begins with exploring the person's dreams for life as an adult. It looks beyond a person's disabilities and helps others see her for her gifts, strengths, and capacities. Person-centered planning does not focus on fixing the person's weaknesses. Instead, it explores possibilities for people to contribute in their communities. Additionally, person-centered planning helps the person build friendships within the community.

The person's dreams and preferences guide the transition planning process. It is critical that the person be actively involved. Sometimes pictures, tactile sign language, or

electronic communication systems are used by the person to talk about his own goals and dreams.

Person-centered planning requires teams of people to think beyond "programs." This may be difficult because parents and professionals sometimes think that a person with disabilities has to go to a certain **place** to receive support services (e.g., group homes, sheltered workshops, or day activity programs). For example, many parents do not think an apartment is an option for their adult child because they were told that apartments are for "high functioning" people with minimal support needs.

A job, a place to live, and leisure activities were designed around the things Karen and Bachie like to do. Karen likes to swim, so her team helped her get a membership to the local YMCA. They also found that one of Karen's favorite activities is digging in the soil, so team members helped Karen become involved in a community garden. Jobs that are very structured with routines work best for Karen. The team found a job for her at a local restaurant where she works part time preparing place settings.

Bachie's team members identified playing with Playdough™ as one of her favorite activities. Since this is an activity most 20 year old women would not do, the team listed as many similar adult activities as they could that were like playing with Playdough™. As a result, Bachie enrolled in a community ceramics class . . . *and the vision continued . . .*

Life in the Community
Turning a House into a Home

Deciding where and how a person with disabilities will live in the future is an important part of the transition process. Teams can assist the person in describing her ideal

future living situation. This includes **where** she wants to live, **who** she would like to live with, and the type and amount of **support** she will need.

A home is not the same as a program. Often programs (e.g., group homes), have a number of rules and regulations that may not give a very "homelike" feeling. Programs may have requirements for people to be involved in "active treatment." These programs may have restrictions on room decorations due to fire codes. Programs often require large numbers of unrelated people with disabilities live together.

Separating housing from support has become a key component in what is sometimes called "supported living." The idea behind supported living is that the person with a disability can purchase support services from an agency that does not own the buildings in which she lives. The agency's role is to provide only the services she wants and needs. Since the agency is not the landlord, decisions about the type housing, and who lives in the house, are left to her. People with disabilities can take control of the home they live in, either by renting or purchasing the housing.

A recommendation was made that both Karen and Bachie move to a large institutional facility because they needed to have a lot of support. However, the people who knew Bachie and Karen described their ideal living situations as "small and family-like." One former staff member said many of Bachie's challenging behaviors would decrease in a setting with fewer people.

Team members envisioned Karen and Bachie living in a typical house or apartment close to town. A home that was uncluttered was important to both young women because of their vision losses. Because both young women enjoy animals, a place that allowed pets was important.

Bachie and Karen had never met each other. Members on their planning team struggled to decide if they would enjoy living together. Both of them needed a roommate, for both financial and social reasons. Since Karen and Bachie had similar interest and support needs (i.e., sensory losses and medical conditions), rooming together seemed to be the answer. Team members felt Karen and Bachie should have a third roommate (without disabilities) living with them to provide the extra support they needed . . . *options are created* . . .

Where are the Jobs?
Being in the Work Force

Work is an important part of adult life. Work allows people to pay their bills, participate in activities they enjoy, and interact with other people with similar interests. People often feel good about themselves when they contribute their time and energy to something worthwhile. Work is important for the majority of people, including people with disabilities.

In the past, people with disabilities often had to work in special places where training and support were provided (e.g., sheltered workshops or work activity centers). Beginning in the early 1980's, people began to think differently about how to best support persons with disabilities on the job. "Supported employment," similar to supported living, is a strategy that allows persons to work in community businesses with support. Persons with disabilities no longer have to go to a certain place to work. Now, they can select from a broad range of career choices.

Transition planning team members help the person plan her future career by developing community work experience sites based on her interests and capabilities. Team members also can help her identify paid jobs that will continue after

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she leaves school. Team members will identify agencies which can provide support services to her, such as a job coach to teach new job skills.

The first priority when Karen and Bachie returned home was to get them settled in their home. Although planning for jobs began early, it took much longer than expected. For example, neither Bachie nor Karen could become eligible for services through vocational rehabilitation until they had an established address in Indiana.

Currently, Karen has a job at Damon's, a local restaurant. Each day, she works from 8:30 a.m. to 10:30 a.m. She wraps silverware in napkins used for place settings. This job is working well for Karen because team members knew from Karen's school work experiences she needed a structured routine, a job that provided tactual information based on her learning style, and a job that did not require a high production rate or speed.

Bachie is not working for pay yet, but is involved in work experiences that help her explore her interests. She volunteers at a church folding bulletins and preparing these for mailing. Since Bachie enjoys cooking, team members also are investigating volunteer work in a local soup kitchen.

Waivers, Wraps, and Other Dollars
Creating a Funding Package

Obtaining funds to support a person's dream is an important part of the transition process. Funding for adult services comes from different sources, each with different requirements about how the money can be spent. For example, "Medicaid Waivers" can be used for a variety of support services, but not for room and board.

Medicaid Waivers are one funding option. Funds from Medicaid pay for medical services and long-term care for people who do not have much income, are elderly, disabled, or blind. In the past, a large portion of Medicaid Waiver funds went directly to large, residential facilities (e.g., institutions). Persons who wanted or needed long-term care services had only one choice; an institutional setting.

Now, states are allowed to use Medicaid Waiver funds differently. Funds can be used to move persons out of institutions or to avoid placements in institutions. Medicaid Waiver funds can be used to purchase a variety of support services that the person may need, such as respite, assistance in the home, adaptive devices, or support on the job. Specific services that a state offers depend on what is written in the Medicaid Plan for the individual state.

"Wrap around services" are another funding source. The Indiana Department of Education provides funding to local education agencies for a variety of specialized student supports. The local education agencies apply for this funding in order to provide the additional support needed to educate the student in the local community.

Another funding source are housing subsidy programs through HUD, such as "Section 8" funding. Persons eligible for Section 8 vouchers and certificates pay just 30% of their income toward rent and the federal government subsidizes the rest. For example, someone whose only income is Supplemental Security Income (SSI) at the maximum benefit rate, would pay $137.40 per month in rent.

Karen and Bachie receive Medicaid Waivers for support services. Team members discovered that both women qualified for wrap around monies since they had not graduated from school before they returned to Indiana.

Finally, team members placed Bachie and Karen's names on a Section 8 housing list in their county . . . *and the funding search continues . . .*

Appendices

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Everson, J.M. (1995). Beyond programs and placements: Enhancing the development of individualized transition services. In J.M. Everson (Ed.), *Supporting young adults who are deaf-blind in their communities: A transition guide for service providers, families, and friends* (pp. 21-41). Baltimore, MD: Paul H. Brookes.

This chapter provides descriptive information on how the personal futures planning process is used in transition planning. Team collaboration among various agencies involved in providing transition related services and activities is emphasized. It gives a step-by-step approach for team members to follow during the transition planning process.

Falvey, M.A., Forest, M., Pearpoint, J., & Rosenberg, R.L. (1994). Building connections. In J. Thousand, R. Villa, and A. Nevin (Eds.), *Creativity and collaborative learning: A practical guide to empowering students and teachers* (pp. 347-368). Baltimore, MD: Paul H. Brookes.

This chapter provides information on various mapping strategies including McGill Action Plans (MAPs) and Planning Alternative Tomorrows with Hope (PATH) which is a branch of the MAPs process. A series of questions are identified for team members to answer during the planning process. Hints for good facilitation of a MAPs or PATH planning session also are included.

Kansas State Board of Education. (1991). *MAPS: A plan for including all children in schools*. **Topeka: Author.**

This manual describes a step-by-step mapping process using a case study approach. Included in this manual are tips on how to get a MAP group started for their children. Comments and quotes from various parents and individuals who have been involved in a MAP process also are included.

Mount, B. (1992). *Person-centered planning-finding directions for change using personal futures planning: A sourcebook of values, ideals, and methods to encourage person-centered development.* **New York: Graphic Futures, Inc.**

This manual provides strategies and steps for guiding personal futures planning meetings. Sample maps and symbol suggestions are included. Several guidelines are provided for conducting effective planning meetings, talking with agency representatives, and how to work with policy makers.

Mount, B., & Zwernik, K. (1988). *It's never too early, it's never to late: A booklet about personal futures planning.* **St. Paul, MN: Metropolitan Council.**

This document provides information on the personal futures planning process in a user friendly way. It is filled with many pictures of individuals working, living, and playing in community settings, as well as sample maps including visions, dreams, and choices.

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Appendix B: Transition Resources

Everson, J.M. (Ed.). (1995). *Supporting young adults who are deaf-blind in their communities: A transition planning guide for service providers, families, and friends.* **Baltimore: Paul H. Brookes.**

This book is an excellent resource for issues involved in transition planning of young adults with deaf-blindness. A chapter as told by consumers presents the feelings and experiences through real life accounts of transition from school to post-school settings. National resources and program contact information also are listed in the appendices.

Everson, J.M. (Ed.). (1995). *Transition services for youth who are deaf-blind: A best practices guide for educators.* **Sands Point, NY: Helen Keller National Center-Technical Assistance Center.**

This monograph provides an overview of transition services commonly overlooked for individuals with deaf-blindness. Some of those areas are orientation and mobility needs (including transportation), communication needs (including interpreter services), and postsecondary education opportunities. Many of the chapters include checklists, forms, and guidelines for team members to use when doing transition planning activities.

Everson, J.M., & Houghton, J. (1994). *Best educational and transitional guidelines for youth who are deaf-blind.* **Sands Point, NY: Helen Keller National Center-Technical Assistance Center.**

These guidelines are useful to transition planning teams and families for monitoring and evaluating the implementation of services and activities through the transition years 14-21. The guidelines are divided in two areas; person-centered services and needs, and program service-centered needs across three age groups; middle school, high school, and postsecondary.

Killiam, S. (1994). *A guide to SSA benefits and work incentives for individuals who are blind.* **Sands Point, NY: Helen Keller National Center-Technical Assistance Center.**

This document includes topics specific to the use and application for Supplemental Security Income and Social Security Disability Insurance. It is presented in a user friendly format that is easy to follow.

Appendix C: Goals, Roles, and Process

An easy way to help guide team members through an activity is to outline the activity using three components: goals, roles, and process. These components will assist team members understanding of the activity's purpose, team members' roles during the activity, and how the activity will be completed step-by-step.

Goal

The goal of an activity is made up of two parts. One part is telling what the end result will be after the activity has been completed. The other part is the purpose of the activity. A goal usually can be written in one sentence and, if necessary, can have subparts.

Roles

Roles are assigned and described so team members understand their responsibilities during the activity. In collaborative teaming, roles often include a facilitator, a timekeeper, a recorder, a reporter, and a watch out (to make sure and evaluate whether members are following the agenda and team ground rules).

Process

The process is a step-by-step description of what team members need to do in order to meet the goal. The steps are listed in a sequential order; the number one step listed first, followed by the second step. This pattern is continued until the last step is reached. It looks like a recipe with all of the ingredients needed to finish the task and the order in which ingredients should be added.

☐ Was the agenda written before the meeting? Does it include timelines and the team member responsible by each agenda item?

☐ Did the chairperson ask for additional items at the beginning of the meeting?

☐ Was a timekeeper assigned to set time limits for each agenda item?

☐ Did the recorder keep attendance, assist in map making, keep meeting minutes, and write items on the action plan during the meeting?

☐ Did everyone participate during the meeting?

☐ Did the facilitator communicate well with other team members by bringing members in who were not participating, testing for understanding throughout the meeting, summarizing agenda items after each was completed, summarizing decisions at the end of the meeting, and closing or redirecting team members who were dominating the discussion during the meeting?

☐ Was an action plan completed at the end of every meeting and given to team members on time?

☐ Was a next meeting scheduled as an agenda item?

☐ Was a Kaizen (satisfaction evaluation) completed at the end of the meeting?

☐ Was the action plan reviewed at the beginning of every meeting to talk about successes, what still needs to be changed, and what needs to continue?

Appendix E: Action Plan

ACTION PLAN   Date _____

| Tasks To Be Completed	Person(s) Responsible	Timeline

An action plan is a document in which activities (**what** needs to be done), persons responsible to implement the activities (**who** is going to do the activities), and the timelines in which the activities are to occur (**when** activities happen) are written during the meeting. Each meeting should start with the action plan and end with the action plan. Activities listed on the action plan should be revisited at the beginning of each meeting to review progress made, activities that need to be changed, or activities that need to be continued. The action plan should be summarized at the end of each meeting. Summarizing activities listed on the action plan gives team members one more opportunity to understand their responsibilities.

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Appendix J: Back Home Again in Indiana: Karen and Bachie's Transition Map

Karen and Bachie's transition from out-of-state educational programs to Indiana began in 1992. The transition effort has involved individuals from education and adult service agencies. Appendix F provides a history of the team members' efforts to make Bachie and Karen's transition happen. A glossary of terms also is included to help with acronyms unique to Indiana. Throughout the map, boxes with solid lines indicate team meetings; dotted lines provide action plan items or information.

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The Dream

Not A
Facility!

A Home
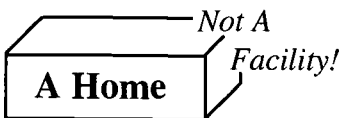
❑ Safe, Comfortable, Stable
❑ Shared
❑ Preferences/Interests Drive Activities
❑ Support (24 hour)
- Householders
- Respite

Meaningful Work

❑ ~~School~~
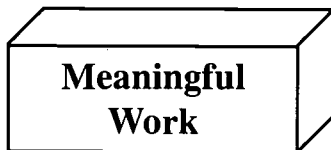
❑ Real Work, Real Job Setting, Real $$
❑ Support (Transition Specialists)

Fun & Friends

❑ Take Part in Community Activities
❑ Communication
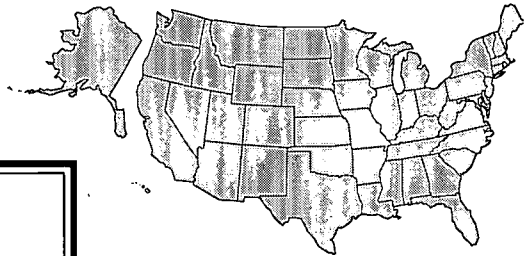- Co-Workers
- Neighbors
- Community Members
❑ Support (Friends)

JUNE '92—Indiana Deaf-Blind Services Project contacted to assist with transition planning by:
- Indianapolis Public Schools,
- NW Indiana Special Education Cooperative,
- Perkins School for the Blind
- Chileda Institute.

Dialogue began—How to transition students from out-of-state???

JUNE '92—IEP
Meeting—Bachie

Attending:
- IN Deaf-Blind Services
- HKNC Regional Rep.
- VR Counselor
- School Reps.
- Parent

Discussed Personal Futures Planning—to happen over the course of the year.

Vision of The Future

AUGUST '92—Indiana Deaf-Blind Services Project Director attends PFP training in Atlanta.

OCTOBER '92—Indiana Deaf-Blind Services Project submits application to HKNC-TAC to participate in interagency project, "The State and Local Team Partnership Model."

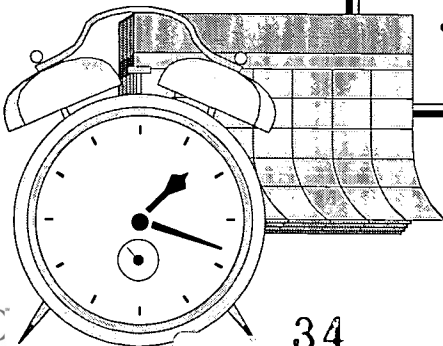NOVEMBER '92—Decision to work directly with local teams rather than through the State and Local Team Partnership Model.

FEBRUARY '93
Team Meeting

- Info. gathered
- Plans for the Future
- Begin planning
- Timelines
  |----|----|----|----|

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MORE INFO. GATHERED
- Indiana Housing Finance Authority
  —Section 8
- City of Indianapolis Planning Division
  —Section 8
  —Purchasing programs

Warning Bureaucratic Caution Zone

MARCH '93—FUNDING
Team Meeting

- SSI
- S-5 WRAP AROUND $$
- Medicaid Waiver $$
- Housing Programs
- Draft Budgets!!

APRIL '93
Two Team Meetings

Input From Adult Providers
- Videos of Karen & Bachie
- Input on budgets
- Assess interest of providers

S-5 Proposals Due

VIDEO - "Planning Today-
          Creating Tomorrow"

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PERKINS CHANGING PRO-
GRAM FOCUS—Needed to
make decision about when
Karen would return to IN.

MAY '93
Team Meeting

Medicaid Waivers
- Karen - eligibility
- Bachie - eligibility

Providers
- Two interested
- Pro's and Con's

JUNE '93
Team Meeting

Housing
- Provider identified
- Negotiations with DOE scheduled
- Ads in paper for staff

Funding (long-term)
- More ideas
- Letter—Line Item $$
- D/B Waiver???

KAREN COMES
HOME FROM
PERKINS!

AUGUST '93
Team Meeting

Budget Issues
- DOE budget negotiations had not occurred.
- Karen approved for Medicaid Waiver!!
- Tasks assigned to continue work on housing $$$.

Housing Status
- Looking at houses the next day.
- Meeting Karen's mother.

CONCERNS ABOUT PHILOSOPHY AND WORKING AS A TEAM!
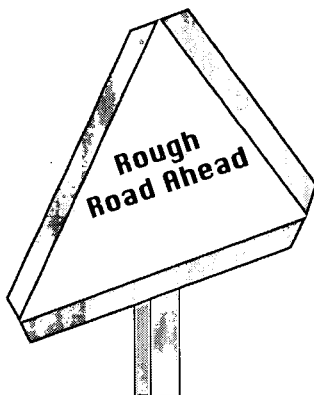
SEPTEMBER '93
Team Meeting

Medicaid Waiver (Karen)
- New case manager
- Developing plan of care

Residential Update
- **Provider did not attend!**
- **Concerns about communication and timelines**

IEI Rep. Joins Team!

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OCTOBER '93
Team Meeting

RESIDENTIAL UPDATE
- **Did not attend** *again!*
- **Duplex sold—no housing**
- **Afternoon interviews with Transition Specialist cancelled**

Concerns—
- Responsibility for the Transition Specialists
- Amount of time spent with Karen
- Communication
- Housing/Timelines ⏲
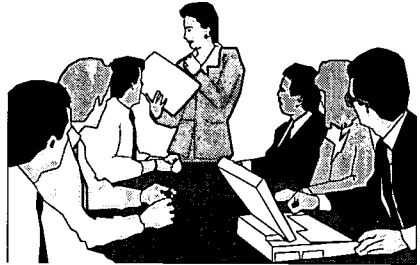
TEAM DECISIONS:
- Need to rethink choice of providers.
- Need to be clear about what we want and need.

NOVEMBER '93
- Group assigned to work on Karen's PFP profile
- Initial taping for "Planning Today-Creating Tomorrow" video

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NOVEMBER '93
Team Meeting

Personal Profiles
- Completed Karen's
- Need to do for Bachie

Respite
- Started calling!!
- Ad—Indy paper

Funding
- CHAS hearings
- Written comments

CHAS HEARING IN
BLOOMINGTON

DECEMBER '93—Team
members meet with staff from
Options For Better Living in
Bloomington:
- Options intrigued and
  excited
- Team members excited
  about Options
- Philosophies match!!

Concerns about:
- Long-term funding
- Training regarding sensory
  impairments

DECEMBER '93
Team Meeting

- Update on meeting with
  Options
  —interested!!!
  —concerns about staff
     training and long-term
     funding
- Update on CHAS hearing
- Karen (respite, ad in
  Bloomington paper for
  Transition Specialist,
  finances)
- Start making contact with
  Voc Rehab

Celebrate!

State Announces
Plan For Decreasing
Medicaid Funding

*Options can't commit
to new ventures
in current
funding climate.*

JANUARY '94
Team Meeting

Review Background/
Clarify Mission

Concerns:
- Medicaid cuts
- Medicaid Waiver budget not approved—needs revision—provider must be identified!
- Options Board won't approve new clients without commitment of long-term funding.
- *Immediate* need for respite!

LETTER WRITING
CAMPAIGN BEGINS!

TEAM SENDS
LETTERS TO:
1) The Governor
2) DDARS, and
3) DOE—budget for K.

FEBRUARY '94
Team Meeting

- Governor's office response
- Options will do it anyway!
- Revised budgets include transition specialist and related services
- Respite started but no contract from DOE
- Arranging visit to meet Bachie in Wisconsin
- Addendum to DDARS letter—affiliate program!

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MARCH '94
- Householders interested!
- Roadblocks to securing funding
- First time client has *not* owned the housing—what if householders don't want to do it anymore???
- Householder Contract:
  — Daily routine to best support Karen
  — Support for house-holders (respite, day program, training)

MARCH '94—House-holders spend the day with Karen and her mother. Everyone is excited!!

MARCH '94
Team Meeting

Meeting to draft Affiliate Proposal to HKNC
- Needs of Hoosiers who are Deaf-Blind
- Outline project objectives

END OF MARCH '94—Options for Better Living submits Affiliate Proposal to HKNC.

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DOE Rejects Budget!!
Need to get things finalized!
—Try another way—

APRIL '94
Team Meeting

Options and Potential House-
holders attend!!
- Setting up visit!!
- Discussing training
  activities—sign language

Redrafting Budget

Plan of Care revised

APRIL '94—Michele
meets with Options
staff in Bloomington
- Budget
- Karen's wants and
  needs

APRIL '94—Karen's
placement conference
at IPS

APRIL '94—
**Affiliate Proposal
Accepted!!!**

MAY '94
- Visits to meet Bachie and her mother
- Speech consultant developing plans with householder and IPS.
- Respite plan developed
- NO WORD ON BUDGET!

KAREN IN HOSPITAL—
Blood sugar levels up!

Options learning more about Karen . . .

Department of Education Approves Budget!$!

JUNE 1, 1994
KAREN MOVES INTO HER NEW HOME!

"Transition Trauma"
(Initially)
- Confusion
- Depression
- Medical Issues

"Stuff" Arrives from Perkins—
(quilt, chair, footstool, skates,
and craft items)

Karen begins to feel at home.

AUGUST '94
Planning Team and Options
Staff Meet Together

Update on Karen
• transition issues
• employment
• medical issues

Bachie's move
• Learning from Karen's
  experiences
• action plan

Technical Assistance Needs

AUGUST '94

BACHIE RETURNS
TO INDIANA!

45
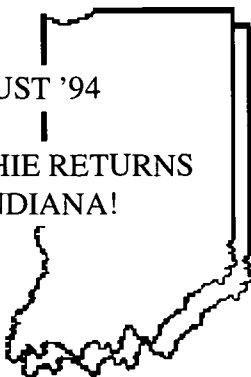
SEPTEMBER '94
Team Meeting

Meeting on employment issues—next steps (sub-group)
- Training for transition specialists
- Linking with VR and Stonebelt Center
- Karen moved to top of Supported Employment lists!

OCTOBER '94
Team Meeting

Updates on Karen & Bachie

"Planning Today-Creating Tomorrow" video

Affiliate Project

CONFLICT BREWING . . .
- Whose house is it anyway?
- Stay or move?

Lessons Learned
- Always separate housing from support!
- Don't give in under pressure!

NOVEMBER '94—Karen and Bachie move to new home with new support staff.

DECEMBER '94
JANUARY '95
Team Meeting

- Medical Issues
- Roles & Responsibilities
- Agency Training
- Bachie & Karen need to have jobs

FEBRUARY '95
Team Meeting

The "fine art of communication"
- agencies
- householders
- families
- medical

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┌─────────────────────────────┐
│        APRIL '95            │
│       Team Meeting          │
├─────────────────────────────┤
│  • Review History           │
│  • The Dream revisited      │
│  • Values Statements &      │
│    Clarifying Roles         │
│  • Roles & Responsibilities │
│  • Next Steps               │
└─────────────────────────────┘
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┌ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ┐
│ JUNE, JULY, AUGUST '95—    │
│ Vocational Planning Meetings│
│                            │
│ Karen gets a job!!!        │
│ Bachie does volunteer work!!!│
└ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ┘
```

and the journey continues...

AAA	Area Agency on Aging
AFA	Alternate Family for Adults. A residential support model in which a "householder" lives with the person who has a disability.
Affiliate Program	A program through the Helen Keller National Center's Field Services Division which provides matching start up funds to agencies that are interested in providing or expanding services for adults who are deaf-blind.
CHAS	Comprehensive Housing Affordability Strategy. A plan that outlines how a community will address the housing needs of low-income individuals. These plans are generally developed by city or state housing authorities depending on the size of the community. Entitlement areas with over 50,000 population can submit their own CHAS. The state housing authority submits a CHAS that covers all non-entitlement areas.
Chileda Institute	A residential school in Wisconsin.

DDARS	Division of Disability, Aging and Rehabilitative Services
Deaf-Blind Waiver	Team members have discussed the possibility of working with the state to include waivers in the state Medicaid plan targeted for individuals who are deaf-blind. These do not exist at this time; however, Indiana does have waivers specifically earmarked for individuals with autism.
DOE	Department of Education
HKNC	Helen Keller National Center. A national rehabilitation agency based in Sands Point, New York, which provides rehabilitation services to youths and adults who are deaf-blind.
HKNC-TAC	Helen Keller National Center - Technical Assistance Center. A federally funded project which provides technical assistance and training to family members, consumers, and service providers around transition issues for youth who are deaf-blind.
Hoosiers	Individuals who live in Indiana. Origin of this term is greatly debated among Hoosiers themselves. It also is the title of a movie starring Gene Hackman.

IEI	Indiana Employment Initiative. A federally funded project housed at the Institute for the Study of Developmental Disabilities at Indiana University that provides technical assistance in the area of supported employment for individuals with severe disabilities.
Indiana Deaf-Blind Services Project	One of the federally funded projects that provides training and technical assistance to families, consumers, and service providers of children who are deaf-blind, ages birth to 22 (similar projects exist in every state, although some are operated through multi-state regional centers).
Indy	Short for Indianapolis.
Integrated Field Services	The mental retardation/ developmental disability (MR/DD) agency in Indiana which helps identify services, residential options, and funding sources.
IPS	Indianapolis Public Schools
Line Item Funds	State funds that are awarded directly to residential service providers by the Division of Disability, Aging and Rehabilitative Services.
Medicaid Waivers	Funds provided through Medicaid that are paid directly to the individual (rather than the agency which provides support services) for purchasing needed services.

Options	Options for Better Living. A residential services program based in Bloomington, Indiana.
Perkins	Perkins School for the Blind, Watertown, Massachusetts
Personal Profiles	Graphically displayed information of a person's history, relationships, schedule, preferences, and choices used in the Personal Futures Planning Process.
PFP	Personal Futures Planning. A process for assisting an individual with a disability to plan for their future in a person-centered manner.
Plan of Care	A plan developed around an individual which specifies his or her support and training needs, and how Medicaid Waiver funds will be used.
S-5 Wrap Around Funds	Indiana Department of Education funds previously used to support students in out-of-state educational placements, that are now being made available to "creatively" support students within Indiana. (S-5 refers to the state rule regarding out-of-state residential placements.)
Section 8	A rent subsidy program which allows low income individuals to pay only 30% of their income toward rent (the Section 8 subsidy will cover the rest).

|	
SSI	Supplemental Security Income
Stonebelt Center	An agency in Bloomington, Indiana, that provides employment support services to people with disabilities.
Transition Specialists	Staff members who are paid to work with Karen and Bachie during the day. Their responsibilities include job development, job coaching, and training/support in recreational and personal management activities.

Mobile Instructions

Side A   Side B
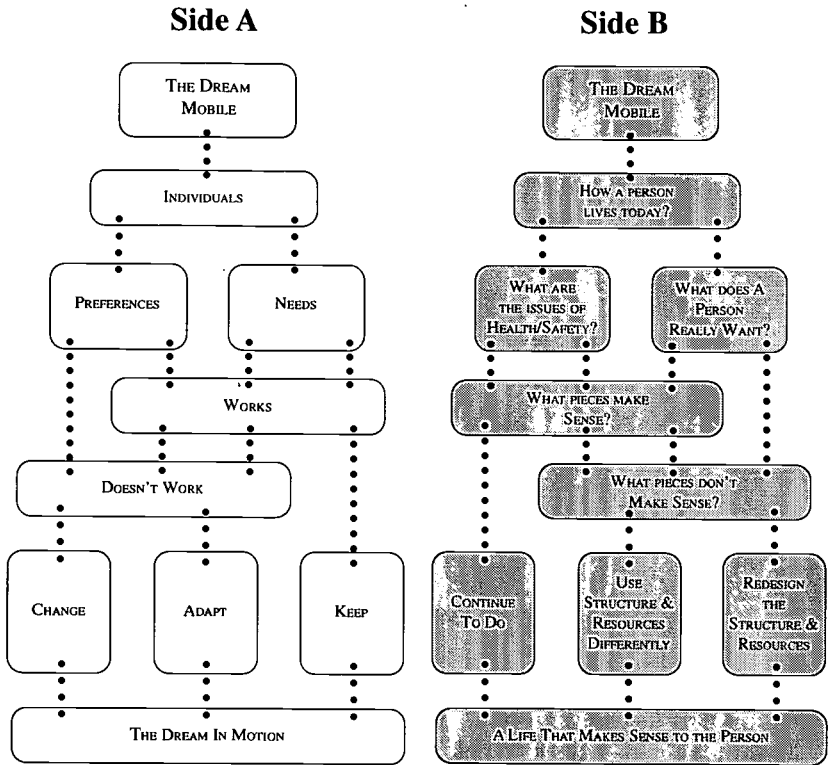
The above diagram is a picture for the two sides of "The Dream Mobile". The following four pages contain all the pieces needed to make it. To begin making the dream mobile, cut all of the pieces pictured on pages 51-54. Then connect the pieces with string (approximately one to two inch segments), by taping the string over the dots printed on the shaded side. When you have finished taping the pieces together, you will have a model to person-centered, transition planning.

THE DREAM MOBILE

INDIVIDUALS

WORKS

PREFERENCES

NEEDS

55

THE DREAM MOBILE

HOW A PERSON LIVES TODAY?

WHAT PIECES MAKE SENSE?

WHAT ARE THE ISSUES OF HEALTH/SAFETY?

WHAT DOES A PERSON REALLY WANT?

DOESN'T WORK

KEEP

ADAPT

CHANGE

THE DREAM IN MOTION

57

WHAT PIECES DON'T MAKE SENSE?

A LIFE THAT MAKES SENSE TO THE PERSON

CONTINUE TO DO

USE STRUCTURE & RESOURCES DIFFERENTLY

REDESIGN THE STRUCTURE & RESOURCES

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