TRANSITION PLAN OFF OF THE AUTISM WAIVER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 60615 (2-2025)

Clear Fields

Name of Waiver Participant	
Name(s) of Parent(s)	
Name(s) of Service Manager	
Date	Date Child Will Transition off of the Autism Waiver
Reason for Leaving the Autism Waiver (aging out, no longer qualifies, etc.)	
Concerns for the Family	
Supports Available to Families After the Waiver Services End	

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest, subject to the penalties of perjury that I am the individual completing this application and that I have provided accurate information.

Service Manager's Signature	Date
Parent's Signature	Date