TRANSITION PLAN OFF OF THE AUTISM WAIVER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AUTISM SERVICES UNIT
SFN 60615 (3-2014)

Clear Fields

Name of Waiver Participant	
Name(s) of Parent(s)	
Name 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	

Service Manager's Signature	Date
Parent's Signature	Date