BRIDGING TO ADULTHOOD:

A Protocol for Transitioning Students with Exceptional Needs from School to Community

Healthy Child Manitoba
Putting children and families first

Manitoba

March 2008

Table of Contents

Preface

Government of Manitoba Interdepartmental Protocols

A protocol is an agreement between two or more departments, agencies or authorities that describes how they will work together to achieve a common goal. It identifies who is responsible, individually or jointly, for specific tasks and their timelines.

Mandate

The Healthy Child Committee of Cabinet directs the province's interdepartmental protocols on service provision for children, youth and families across the province. These protocols mandate a co-ordinated approach by the staff of departments and related organizations (schools, regional health authorities, child and family services authorities and other designated agencies) who work with children, youth and their families.

The following protocols are available on the Healthy Child Manitoba website at www.gov.mb.ca/healthychild:

- *Guidelines for School Registration of Students in Care of Child Welfare Agencies (2002)*
- *Guidelines for Early Childhood Transition to School for Children with Special Needs (2002)*
- *Interdepartmental Protocol Agreement for Children/Adolescents with Severe to Profound Emotional/Behavioural Disorders (1995)*
- *Information Sharing Protocols Under the Youth Criminal Justice Act (Canada) (2004)*
- *Bridging to Adulthood: A Protocol for Transitioning Students with Exceptional Needs from School to Community (2008)*

Introduction

Purpose

Bridging to Adulthood: A Protocol for Transitioning Students with Exceptional Needs from School to Community:

- directs provincial government departments to support cross-departmental policy development and co-ordinate administrating bodies who work directly with students who have exceptional learning needs which include school divisions, institutional schools (including those in correctional and treatment facilities residential settings) regional health authorities, and child and family services authorities
- outlines the interactive roles and responsibilities of transition planning partners and their timelines
- provides guidelines and support materials for transition planning and implementation

This document replaces *Manitoba Transition Planning Process Support Guidelines for Students with Special Needs Reaching Age 16* (1999). It is intended for transition planning partners, including Manitoba Family Services and Housing, designated agencies, Child and Family Services Authorities and Agencies, Manitoba Health and Healthy Living, regional health authorities and their programs and services, Manitoba Education, Citizenship and Youth and educators in Manitoba.

As students enter the senior years, they must begin to plan for their options in life after High School. The goal is to help partners better support students with exceptional needs who require supports from the provincial government, its agencies and/or Regional Health Authorities after leaving school. This includes students with mental, learning, physical and psychiatric disabilities, persons with spinal cord injuries and persons with a visual disability or who are Deaf or hard of hearing. The transition planning process facilitates timely access to available adult supports. Supports may assist individuals to contribute to the economic, social and cultural life of Manitoba.

Section One

*Protocol for Transitioning Students
with Exceptional Needs
from School to Community*

THE TRANSITION PROTOCOL –

Interactive Roles
and Timelines

The transition protocol identifies who is responsible for developing and implementing transition plans for students with exceptional learning needs when they require government supports to enter the community. It outlines the tasks and their timelines.

Partners in transition planning include:

- the student and his/her support network (which may include: parents[1] and/or legal guardians, siblings, friends, advocates, foster parents or group home staff)
- teachers and school/school division staff/institutional school staff
- community workers from Manitoba Family Services and Housing programs including:
  - Children's Special Services (CSS)
  - Employment and Income Assistance (EIA)
  - Vocational Rehabilitation (VR) program
  - Supported Living program (SLP)

  or designated agencies including CNIB, Society for Manitobans with Disabilities (SMD), Canadian Paraplegic Association Manitoba Inc.(CPA)

- community workers from regional health authority (RHA) programs in Manitoba including:
  - Community Mental Health (MH) services
  - Home Care program
- community workers from applicable child and family services (CFS) agencies

Transition planning should begin in the school year in which the student enters high school. The process concludes in June of the calendar year in which the student turns 21 or when he/she graduates. During this time, professionals, the student, his/her support network and others work together to provide the student with a co-ordinated transition from school to life in the community.

The transition planning protocol is summarized in Figure 1. The shaded rows outline key responsibilities of transition partners. The columns identify timelines for specific tasks.

See Appendix A for an interactive roles and timeline checklist for case managers.

---

[1] In some cases only one parent or legal guardian may be involved in a child's educational and transition planning. The term "parent" in this document can apply to any of these. The rights and responsibilities of parents may also apply to students once they have reached the age of majority. For information on *The Vulnerable Persons Living with a Mental Disability Act*, see Appendix H.

Figure 1 - *Interactive Roles and Time Lines In Transition Planning*

INITIATING THE PROCESS **High School Entry** **(Age 14 to 16)**	*Age 16 to 17*	*AGE 17 to 18*	
Students and/or parents/guardians with support networks, substitute decision maker(see Appendix H), teachers,			
• become aware of options & planning process • think about potential community experiences, graduation date, adult options • provide information on strengths/ interests/ dreams	• explore residential support services of personal preference or plan to reside in family home • understand the implications of leaving school before completing graduation requirements, or availability of adult supports	• at age 18 a person with disability may contact Employment & Income Assistance for assessment of eligibility • apply for appropriate ID • age 18 may involve move to adult residential facility with support from adult programs (ex: SLP,MH)	
School			
• appoint case manager for transition planning • co-ordinate initial planning meeting with those closest to student (IEP team) • begin appropriate work/community experiences * • explore potential grad date and senior years programming direction with student, family and IEP team • inform families about adult support options & transition planning process • contact adult program (SLP, MH, VR) where no children's worker involved or co-ordinate contact with children's worker	• co-ordinate annual transition planning meeting • research eligibility criteria for adult programs • initiate referrals to adult programs (SLP, VR, MH) in consultation with parents • include adult worker in IEP/ITP meetings • assist with gathering information regarding supports required at home & in community	• co-ordinate annual transition planning meeting • increase focus of instruction towards priority outcomes for transition • advocate for establishment of community supports for adult life, where none currently exist	
* May include ongoing career development, volunteer experiences, exploration of day programming options, exposure to recreational opportunities, transportation training, skills for living in the community with independence etc.			
Services for Children			
Child and Family Service Agencies* • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements • complete referrals for appropriate adult services in collaboration with the parents • attend school transitional planning meetings *Note: For children in care of child and family services agencies, CFS/legal guardian should be involved in the process whenever a parent would be involved	• complete referrals for appropriate adult services in collaboration with the family • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility • participate in school transitional planning meetings to ensure continuity of planning for services and supports	❏ continue to plan and make referrals to appropriate adult resources	
Children's Special Services, • inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements • complete referrals for appropriate adult services in collaboration with the parents • attend school transitional planning meetings	• complete referrals for appropriate adult services in collaboration with the family • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility • participate in school transitional planning meetings to ensure continuity of planning for services and supports	*In consultation with adult worker* • continue to plan and make referrals for required supports	
Children's Mental Health • inform the family about the transition planning process and discuss potential adult service options (EIA, VR etc.) and eligibility requirements • complete referrals for appropriate adult services in collaboration with the parent/legal guardian • attend school transitional planning meetings	• complete referrals for appropriate adult services in collaboration with the family • link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility • participate in school transitional planning meetings to ensure continuity of planning for services and supports	*In consultation with adult worker* • continue to plan and make referrals for required supports	

	One year Before Graduation	*Graduation Year*
siblings, relatives, friends, advocates, foster parents or group home staff		
	• plan for post-secondary education/ training, work/community placement, or vocational/day service • choose supports that match individual preferences/needs or advocate for new/enhanced services	• make informed decisions about - employment - move to post-secondary education/training, work/community opportunities - accessing a variety of supports/services from community based service providers.
	• co-ordinate annual transition planning meetings • increase work/community experiences* • ensure curriculum supports a planned move to post secondary education/training • Ensure completion of SLP day services: information gathering and referrals • include assigned adult community worker in planning meetings • identify resources required: work/community	• co-ordinate annual transition planning meeting • include assigned VR community worker in planning meetings and provide with current information • ensure graduation/completion requirements have been met • initiate long-term work/ community experience* • co-ordinate continuity of supports with adult community worker or with work/community representative
	• a child and family services agency may continue involvement beyond age 18 for children who are permanent wards under the guardianship of the CFS agency, depending on individual circumstances	

INITIATING THE PROCESS **High School Entry (Age 14 to 16)**	*Age 16 to 17*	*AGE 17 to 18*	
Services for Adults (Employment and Income Assistance, Supported Living Program, vocational rehabilitation services,			
• provide transition team with general information re referral process, eligibility criteria, & adult service options **Home Care Program** • receive referral and conduct assessment to determine eligibility • provide information on adult resources • case co-ordinator collaborates in developing care plan • case co-ordinator arranges services specified in care plan • participate in the facilitation of alternate residential placement in community	**Supported Living Program (SLP)** • acknowledge receipt of referral, check eligibility & assign community worker • community worker participates in planning meetings with transition team (at least one before assuming case responsibility) • provide information on adult supports/ service providers • request for funding for residential/support services if required at age 18 • complete referrals to residential service provider of choice as required • provide information for establishment of community supports for adult life, where none currently exist **Day Services** • check eligibility & assign community worker • provide information on adult programs and resources in community	**Regional Health Authorities (RHA)** **Mental Health (MH) Services and Supports** • check eligibility and assign community worker • assigned worker participates in planning meetings (at least one before assuming case responsibility) • provide information on adult resources • complete referrals to adult resources • request for funding for residential and/or support services if required at age 18 **Home Care Program** • assess and facilitate request for funding for residential/support services if appropriate at age 18	

	years where overlap may occur	
	One year Before Graduation	*Graduation Year*

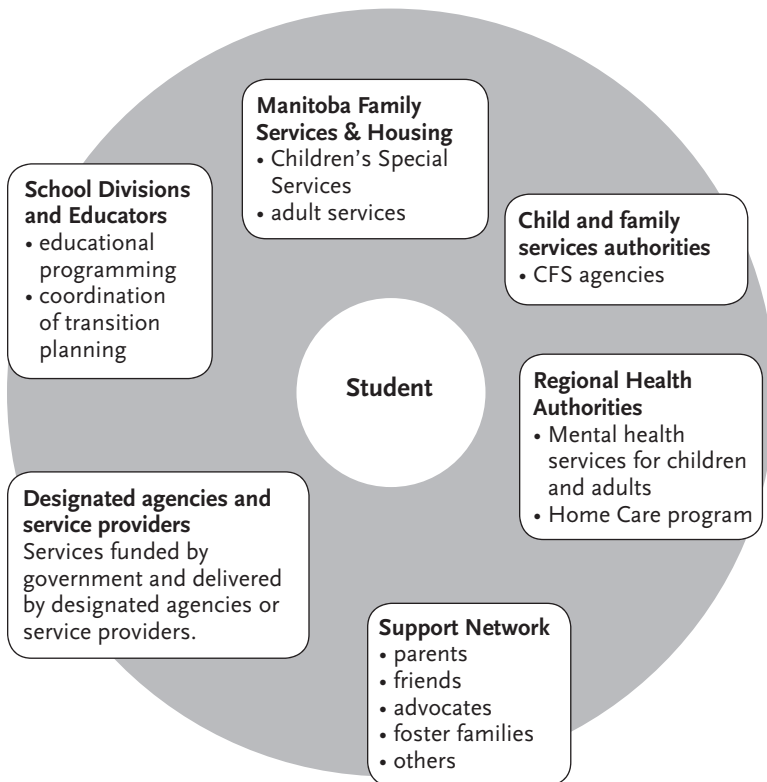| mental health services and supports, Home Care Program)		
	Employment and Income Assistance • apply in person at age 18 and beyond	
	Vocational Rehabilitation Program FSH, RHA, designated agency (SMD, CNIB, CPA) • acknowledge receipt of referral, check eligibility & assign community worker • community worker participates in meetings with transition team • provide information on adult supports/ service providers • develop individual vocational plan • identify and initiate referral to service provider of choice and request funding for services, including technical assessments, upon student leaving school	
	Supported Living Program (SLP) – Day Services • ensure completion of previous steps in the referral process • community worker participates in meetings • request funding for day service resources two years before graduation date • referrals to day service resources and adult clinical services	

Interactive Roles and Responsibilities in Transition Planning

Manitoba Transition Support System

Transition planning for students who will require government supports when they move from school to life in the community is necessary to ensure co-ordinated service delivery. The transition planning process demands significant collaboration between students, their family/support networks, school divisions, educators and government and community service providers who are responsible for implementing the transition protocol. To accomplish a successful transition, it is important that all those involved with the students work together and fulfill their individual roles and responsibilities.

Figure 2 identifies key supports that may be involved with students in the transition process.

Fig. 2
Manitoba Transition Support System

Students

Students are the central member of the transition planning team. Their role is critical in goal setting and decision making. Students and their support networks should be active participants in transition planning. Support networks may include parents/legal guardians, siblings, relatives, friends, teachers, advocates, foster parents or group home staff.

Students, with help from their support networks, may participate in transition planning by:

- attending IEP/ITP meetings
- sharing information on his/her interests, skills and hopes for the future with the team
- becoming aware of options and the planning process
- participating in assessment designed to identify current skills and needs
- expressing his/her opinions in the decision making process
- thinking about potential community experiences, graduation date, adult options
- choosing preferences for residential support services or planning to reside in their families home
- understanding the implications of leaving school at age 16 or 17, or graduation before adult supports are available
- at age 18, contacting Employment and Income Assistance for assessment of program eligibility

For legislation affecting transition teams, – see Appendix H.

School Divisions and Educators
- educational programming
- coordination of transition planning

Manitoba Family Services & Housing
- Children's Special Services
- adult services

Child and family services authorities
- CFS agencies

Student

Regional Health Authorities
- Mental health services for children and adults
- Home Care program

Designated agencies and service providers
Services funded by government and delivered by designated agencies or service providers.

Support Network
- parents
- friends
- advocates
- foster families
- others

- at age 18, considering a move to an adult residential facility with support from adult programs (ex: Supported Living Program)
- planning for post secondary education/training, work/community placement, or vocational/day service
- choosing supports that match individual preferences/needs
- working hard to complete school requirements

Parents, Legal Guardians, Foster Parents, Caregivers and Support Networks

Parents, legal guardians, foster parents, caregivers and others legally authorized to make decisions are also key members of the transition team. They can ensure that transition planning reflects the interests and values of the student.

The school principal must ensure that parents and students have the opportunity to have a person of their choosing in the process and attend planning meeting, etc.

The suggested roles of these team members include:

- attending IEP/ITP meetings
- sharing their knowledge students' interests, strengths and needs with the team

- supporting the students in the transition process
- participating in the decision making process
- encouraging and helping students participate in transition planning
- finding information on available services and resources, currently or after graduation
- supporting implementation of the plan
- sharing information about students' progress
- becoming familiar with *The Vulnerable Persons Act* (see Appendix H)

A Family Guide to the Vulnerable Persons Act is available at: www.aclmb.ca/Guides/VPAfamily_Guide.pdf

Interactive Roles and Responsibilities of Educators

Appropriate Educational Programming in Manitoba: Standards for Student Services (2006) reinforces the transition planning protocol for students who will need adult supports. Teachers' roles are also outlined in the *Pupil File Guidelines* (2004). They are available at:

www.edu.gov.mb.ca/k12/specedu/aep

www.edu.gov.mb.ca/k12/docs/policy/mbpupil/index.html

Student Services Administrator

Consistent within Appropriate Educational Programming in Manitoba, the student services administrator or designate within a school division assumes a leading role in transition planning and is responsible for:

- initiating contact early in the school year (at the latest by November 30) with designated personnel from Manitoba Family Services and Housing, regional health authority programs and services, child and family services agencies and others to discuss planning for identified students within the division
- providing consultation and professional learning opportunities to equip the case manager and the school staff for transition planning for students with exceptional learning needs

School Principals

Principals are responsible for students' Individual Education Plans and transition planning which includes:

- initiating planning for students entering high school who may require adult supports and services when they leave school
- identifying planning case managers within the school and ensuring planning involves teachers and other school staff
- ensuring that transition planning is co-ordinated with students' educational programming
- involving the registered nurse in transition for Unified Referral and Intake System (URIS) Group A students
- ensuring the involvement of child and family services agencies, Manitoba Family Services and Housing and/or designated agencies (CNIB, Society for Manitobans with Disabilities and Canadian Paraplegic Association Inc.) and/or regional health authority programs and services
- ensuring planning is updated annually, or sooner if required
- ensuring parents are meaningfully involved in decision making
- ensuring parents have the information they need to make informed decisions
- ensuring students' parents and students have the opportunity to have a person of their choosing at individual planning meetings
- establishing, maintaining and retaining a pupil file for each student in a school
- transferring the pupil file and pupil support file of students transferred to another school, within one week of the new school requesting it

---

Determining when a student's right to attend school ends:

Students have the right to attend school until they graduate or until June of the calendar year in which they turn 21. To determine when a student's right to attend school ends, add 21 to their year of birth. For example:

- Sharad's birthday is Feb 15, 1990. He is eligible to attend school until June, 2011.
- Courtney's birthday is December 10, 1990. She is eligible to attend school until June, 2011.

Case Managers (Transition Planning)

Case managers are designated by principals and they assume the major responsibility for co-ordinating the transition planning process. The educational activities of the student should be infused with transition planning. Principals should assign school staff (ex: student services teacher, classroom teacher, counsellor,) who have responsibility for the educational programming of the student as the case manager, unless another professional is more appropriate. Specific roles of case managers in transition planning include:

- scheduling and facilitating transition planning meetings
- determining graduation dates along with students, parents or legal guardians
- determining members of transition planning teams in consultation with students and parents
- facilitating agreement about the roles and responsibilities of members
- monitoring implementation of transition planning
- maintaining transition planning documents (ex: student assessments, transition planning file, documentation of the plan, meeting notes and other related materials)
- updating plans annually and keeping pupil files current
- maintaining communication with team members, students, parents or legal guardians
- helping the student and parents find services and resources available in the community

- ensuring appropriate referrals are made to the necessary adult support programs

Teachers

Students' educational programming should be a part of the transition planning process. The commitment and collaboration of teachers (resource teachers, special education teachers, classroom teachers, subject teachers, guidance counsellors) who are involved with the students are critical. Teachers' roles may include:

- assessing the student's strengths, needs, interests and performance
- making connections between the transition planning goals of the students with their educational goals
- to help students who want post secondary education identify the requirements and prepare accordingly

School Division - Student Services Staff

Student services staff who are closely involved with transitioning students may become members of the transition planning team. They may include speech and language pathologists, occupational therapists, social workers, psychologists, etc. They may:

- identify specific ongoing needs of the student including service requirements
- provide assistance to increase independence and potential of the student to successfully adapt to and maintain a more independent adult life

Interactive Roles and Responsibilities of Community Workers from: Manitoba Family Services and Housing, Regional Health Programs/Services and Child and Family Services Agencies

Children's Services Workers

Workers from Manitoba Family Services and Housing, services provided by regional health authorities and child and family services agencies who are involved with the student, should participate in the transition planning process until the team agrees that a transfer to appropriate adult services is completed.

Children's Special Services

Manitoba Family Services and Housing's Children's Special Services (CSS) program provides services and supports to birth, extended or adoptive families who are raising children with developmental and/or physical disabilities. Services and supports are available through regional offices that are located throughout the province.

The roles of the Children's Special Services in the transition planning process may include:

- informing the family about the transition planning process and discussing potential adult service options and eligibility requirements (EIA, VR, etc.)
- completing referrals for appropriate adult services which include supporting documentation/current assessments in collaboration with the family and school
- attending school transitional planning meetings
- connecting adult service worker(s) to the family when eligibility is confirmed
- participating in school transitional planning meetings to ensure continuity
- working with adult service workers to provide ongoing planning and referrals

Child and Adolescent Community Mental Health Workers

The roles of child and adolescent community mental health workers, from services provided by regional health authorities may include:

- attending transition planning meetings to provide current information to the team on available services and supports
- helping students, parents, school teams and support networks explore and determine appropriate adult supports and residential options
- making referrals to appropriate programs for adults within recommended time lines
- connecting with assigned adult services workers to co-ordinate supports and services
- helping students and families find potential resources in collaboration with adult services workers and school teams

Child and Family Services Workers

The roles of the child and family services agency workers may include:

- attending transition planning meetings to provide current information to teams about available services and supports
- helping students, parents, school teams and support networks find appropriate adult supports and residential options
- making referrals to appropriate programs for adults within recommended time lines
- connecting with assigned adult services workers to co-ordinate supports and services
- helping students and families find potential resources in collaboration with adult services workers and school teams

Adult Services Workers

Adult services workers from Manitoba Family Services and Housing, designated agencies and regional health authority programs/services must be involved in transition planning. One or more of the following programs may be considered, depending on the needs of the student:

- Employment and Income Assistance
- Supported Living Program
  - Day Services
  - Residential
- Vocational Rehabilitation Program (through Manitoba Family Services and Housing; or designated agency, CNIB, Society for Manitobans with Disabilities, Canadian Paraplegic Association Inc.)
- Community Mental Health Services
- Home Care Program

Support programs determine the student's eligibility for services. Once eligibility for a support program is determined and the availability of the program is confirmed, the roles of the adult worker may include:

- providing information to students, parents and school teams on adult programs and services (ex: residential, vocational and recreational) available in the community
- making referrals to appropriate community adult programs and services and needed resources
- ensuring wherever possible that adult services are in place for students when they graduate
- working with students, parents and school teams in annual transition planning meetings as necessary (at least one annual transition planning meeting before assuming case responsibility)

Community Service Providers

Community service providers include government funded community organizations that may provide direct services for those eligible for adult supports. Community service providers may help transition planning teams by:

- attending transition planning meetings as required
- presenting specific information to teams about their services
- assisting the team in determining the knowledge and skills critical for the student to transition successfully to adult supports (suggestions for high priority outcomes)
- providing direction for students and planning teams in preparing for, obtaining and maintaining employment (through assessment and assistance in developing work training outcomes and methods)

ADULT SUPPORT PROGRAMS AND SERVICES

Adult Support Programs and Services Administered by Manitoba Family Services and Housing or Designated Agencies

Adult supports for individuals with exceptional needs may be provided by Manitoba Family Services and Housing through regional offices or through designated agencies including:

- Employment and Income Assistance
- Supported Living Program
  - Day Services
  - Residential
- Vocational Rehabilitation

These programs may include assessment, planning, information, referral, guidance, counselling, treatment, skill development and resource development.

There are eligibility requirements for adult support services. Applicants must be Manitoba residents who are Canadian citizens or legally entitled to live and work in Canada. A registered member of an Indian Band in Manitoba must have established a permanent residence off-reserve before a referral or request for services.

The Student, along with their transition planning teams should contact their regional service centres early in transition planning for complete details on available programs, including eligibility requirements.

Employment and Income Assistance (EIA) for Persons with Disabilities

Employment and Income Assistance is provided through regional offices of Manitoba Family Services and Housing.

Applicant must:

- have a documented mental, learning, physical, psychiatric or sensory disability
- live in the community or in a long-term or chronic care facility
- need financial assistance to meet his/her needs

Supports Available

Employment and Income Assistance includes the following services for eligible participants:

- Income Assistance: provides funds or services to help meet a person's basic needs, including a living allowance, an allowance for shelter (rent, room and board, residential care charges) and essential health services. (Note that health services through EIA cover the cost of essential health needs, including drugs, dental services and optical supplies
- Income Assistance for Persons with Disabilities: provides an additional monthly financial benefit to assist people with disabilities with the additional cost of living with a disability in the community.
- Work Incentive Program: allows program participants to keep a portion of their earned income and still receive benefits from the Employment and Income Assistance Program. Under this program, recipients will always have more money if they work, than if they do not.

Timelines for Referral and Service Provision

An in-person application may be made at age 18.

Supported Living Program (SLP) – Residential and Day Services

Services are co-ordinated through community service workers to meet the unique needs of each individual. Supports and services are accessed through regional offices across the province as available.

Applicants must:

- have documented, significantly impaired intellectual functioning accompanied by impaired adaptive behaviour existing before reaching the age of 18
- be a Canadian citizen or adult legally entitled to permanently remain and work in Canada and a resident of Manitoba

A. Residential Services

Residential services include a range of supports to help individuals live in the community. Options include:

- independent living with supports – provides skill development and support enabling adults to live on their own
- family home – supports are provided so an individual can live with parents or extended family
- residential care facilities – operated by an agency or private operator to provide accommodation, care and support consistent with individual needs

A self-directed program, In the Company of Friends, which links participants with volunteer support networks in the community, may also be available.

B. Day Services

Day services include a range of supports and training to help individuals participate in the community through one or more activities:

- supported employment and follow-up services to support individuals in paid jobs in community settings
- vocationally focused services to help develop, maintain and enhance vocational and social skills, provided in a day service facility or community setting
- personal development services to develop, maintain and enhance an individual's personal care and social skills, emotional growth, physical development and community skills

Age for Service Availability:

- residential services:
  at age 18
- day services:
  July of the calendar year an individual turns 21

Vocational Rehabilitation

Vocational Rehabilitation services may be delivered or co-ordinated by:

1. **Provincial Government** -- Vocational rehabilitation counsellors are located in the Manitoba Family Services and Housing (FSH) regional offices in rural and northern Manitoba and in community area offices in Winnipeg. FSH provides vocational rehabilitation services to persons with mental, learning or psychiatric disabilities.
2. **Regional Health Authorities** – Mental health workers are located across the province thorough RHAs and provide services to persons with psychiatric disabilities. Some regions also employ employment development specialists.
3. **Designated Agencie**s – Some agencies receive provincial funding through FSH to provide services to persons with specific disabilities. The three designated agencies are:
   a. Society for Manitobans with Disabilities Inc. – provides vocational services to persons with a physical disabilities including the Deaf and hard of hearing (excluding persons with a visual disability or spinal cord injuries).

b. Canadian Paraplegic Association – provides vocational services to persons with spinal cord injuries.

c. CNIB – provides vocational services to persons with visual disabilities.

Applicant must meet specific eligibility criteria and be able to enhance his/her ability to regularly pursue employment through voluntary participation in rehabilitation/training process appropriate for his or her individual needs and vocational goals.

Service Options

The Vocational Rehabilitation Program helps participants develop an appropriate vocational plan based on their unique needs, interests and abilities. The implementation of the individual vocational rehabilitation plan may involve a single referral or a multi-year training plan, including a variety of services, as follows:

- School-to-Work Transition Program: provides funding to purchase supports designed to facilitate the transition of eligible students from school to paid employment.

- Post-Secondary Education and Training: may provide funding support to assist individuals to enrol in University or Community College programs.

- Vocational Training: through a range of Assessment and Employment Services as well as training on the job.

- Support Services: such as building or vehicle modification, technical aids or devices, special equipment, transportation, tutors, interpreters, sign language or note taking are also made available to assist or enable the individual to pursue training or employment goals.

- Job Placement: assistance with resume preparation, making contacts with job placement services, job referrals and job development services.

- Employment Support Services: are time limited and may be funded to support individuals with work-related issues impacting on the ability to maintain employment.

Age for Service Availability:

- Age 16 or over and not attending school.

Inquiries for Employment and Income Assistance, Supported Living Programs, Vocational Rehabilitation Program, and other services from FSH:

Contact information for FSH regional offices is available at:
www.gov.mb.ca/fs/locations/ruralnorthern.html
(rural or northern regions of Manitoba)
or www.gov.mb.ca/fs/locations/winnipeg.html (Winnipeg).

Inquiries for vocational rehabilitation services from the designated agencies should be directed to:

Society for Manitobans with Disabilities: www.smd.mb.ca/contact_us.aspx

The Canadian Paraplegic Association: www.cpamanitoba.ca/

CNIB Vision Health Vision Hope www.cnib.ca/en/mb-sk/Default.aspx

Adult Support Programs Funded by Manitoba Health and Healthy Living

Adult support programs may be available through regional health authorities (RHAs) and include the Community Mental Health Services and Home Care Program

RHAs deliver mental health services including planning, delivery and ongoing management of services in Manitoba. Community mental health workers provide services through the RHAs and Community Mental Health Services.

Questions about the responsibilities at the local level can be directed to the **regional health authorities** at www.gov.mb.ca/health/rha/contact.html

Community Mental Health Services

Community mental health provides comprehensive assessment, case management, rehabilitation/treatment, counselling and crisis intervention, community consultation and education. Community mental health services staff help people with mental illness develop coping and living skills. They also help them find other community services they may need.

Eligibility for Community Mental Health Services

Each RHA has its own eligibility criteria and intake process. However, there are some common standards:

- Services are for individuals with mental health problems that compromise their capacity to participate in major life activities such as family life, employment, education, community or social relations (ex: schizophrenia, major affective disorders, bipolar disorders, anxiety disorders).
- Participation is voluntary and requires the informed consent of the individual for referral.
- Services are usually for individuals 18 years of age or older, who are residents of the regional health authority.

RHAs can set their own eligibility criteria and intake process. To find out about specific eligibility criteria applicants or their designates must contact the RHA where the student resides.

In addition to the services provided by community mental health workers, RHAs may have a variety of additional programs. It is important to consult the home region of the student about the services available locally.

Timelines for Referral and Service Provision

- Referral: at age 17
- Potential timeline for service to be available: at age 18 or older

Home Care Program

The regional health authorities deliver the Home Care Program including planning, delivery and ongoing management of services.

The RHA's are responsible for:

- accepting referrals and determining eligibility for home care services, based on a multi-disciplinary assessment
- developing a plan of care which takes into account the needs of the individual and family as well as available community resources
- determining the amount and type of services to be provided

Section Two

*Support Guidelines for Implementation
of Bridging to Adulthood:
A Protocol for Transitioning Students
with Exceptional Needs from School to Community*

Person-Centred Transition Planning

Person-Centred Planning

Students go through different stages of transition during their school years, from preschool to school, from early years to middle years, from middle to senior years and from school to adult life. These stages often involve changes in environments, roles and responsibilities, needs, and/or social relationships. The transition from school to adult life causes substantial changes in the lives of students and families.

Person-centred planning strives to provide services and supports that meet the specific needs of the individual. To do this, the participation of the student is key and their interests, strengths and circumstances are the foremost factors to consider. A person-centred planning process will involve key people working together to develop a transition plan that meets the student's needs, using available resources or, advocating for new or enhanced services.

Person-centred transition planning may include:

- pursuing academic areas of interest and continuing meaningful involvement in school life past age 18
- celebrating the completion of high school through the graduation ceremony with peers, and then shifting focus towards life/work preparation with continued support from the school
- pursuing a combination of volunteer and work experience through the school
- shifting school focus towards meaningful participation in community life (volunteerism, recreation) in increasing independence/ interdependence
- high school completion after four years and transition to the support of a community service provider
- preparation for post secondary education after high school

Person-Centred Transition Planning

Individual students' strengths and needs are always unique and may require many co-ordinated services for successful transition. A student's current level of performance in transition areas all become a part of a student profile that influences his/her transition planning. Considering a student's individual strengths and needs helps ensure a successful transition.

Goals and Objectives

The goal of person-centred transition planning is to help students achieve an optimum quality of life as they become adults in the community. An effective team will:

- identify the student's interests, preferences, strengths and needs
- involve and empower the student and family in the transition process
- increase the capacity of the student for meaningful participation in community life
- identify potential post school options (e.x: recreation, education and/or community life)
- identify and secure required resources and supports for successful transition
- ensure that implementation plans are made
- involve the student, family and other team members in carrying out the plans

Effective Practices in Transition Planning

The following principles should be considered in transition planning:

1. early co-ordinated planning
2. student, parent and support network involvement
3. team collaboration
4. inclusive, community-based approaches

5. developing a student's self-determination and self-advocacy skills

6. comprehensive and functional approaches

1. Early, Co-ordinated Planning

Early planning gives teams sufficient time to understand the student and their needs, develop his/her potential, secure necessary resources and explore opportunities. To be effective, transition planning should re-visit the goals, activities, roles and responsibilities of team members, as the student grows older.

2. Student, Family and Support Network Involvement

Student and family involvement (parents, siblings, grandparents) is fundamental to ensuring students' needs, interests and capabilities are reflected in the transition planning process.

The student is the central member of the transition planning team. His/her role is particularly central in goal setting and decision making. The roles of the student in transition planning include:

- attending individual planning meetings, if possible
- sharing information on his/her interests, skills and hopes for the future
- participating in assessment designed to identify current skills and needs
- identifying goals in transition planning
- expressing his/her opinion in the decision making process
- fulfilling his/her share of the responsibilities to reach the goals of the plan

Parents are key members of the team who can ensure that transition planning reflects the interests, benefits and values of the student. Suggested roles of parents include:

- understanding the transition planning process and obtaining relevant information
- attending IEP/ITP meetings
- sharing their knowledge of their child's interests, strengths and needs
- helping their child identify goals achievable with effort
- offering opinions and participating in the decision making process of transition planning
- encouraging and helping their child participate in transition planning
- finding information on services and resources available, currently or after graduation
- helping their child carry out the responsibilities assigned to him or her in the transition plan
- helping their child develop independence and self-determination in everyday living

Strategies to support student involvement include:

- previewing the agenda of team meetings with the student
- providing the student with an orientation on the general process of transition planning
- helping the student understand his/her role and responsibilities in transition planning and the significance of his/her participation
- using an alternate/augmentative communication system for the student if he/she has difficulty communicating
- ensuring sufficient opportunities and time for the student to express opinions and make decisions
- making transition planning meetings personal and welcoming to the student, by inviting individuals with whom the student feels comfortable and arranging a welcoming environment (ex: preparing snacks, playing music, providing comfortable seating)

- visiting various placement options or programs to help their child make decisions for future options (ex: residential, vocational, recreational)
- sharing information about their child's progress

Along with the student and the family, members of the student's support network who can provide valuable input for transition planning should be included in planning. A support network may include siblings, friends, advocates, foster parents, group home staff, etc.

3. Team Collaboration

Transition planning may involve many partners from various disciplines and organizations including school divisions, government, designated agencies, service providers, advocates, Manitoba Justice and the community. It is critical to establish and maintain a collaborative team to effectively support the student through transition from one support system to another.

A collaborative approach allows team members to communicate and share information and resources. Effective, accountable, seamless transition planning relies on team collaboration. Clarification of the roles and responsibilities of the members is also crucial.

4. Inclusive, Community-Based Approach

No matter how intense and complex the needs of a student are, everyone has the right to be included as part of the community as students and into adult life. For students with exceptional needs, limited experiences in the community and a lack of contact with peers will be an indicator of limited potential for inclusive community life. It is important for students to be a part of inclusive communities inside and outside of school so they can reach their goals in areas such as social relationships and employment. In inclusive schools, transition planning should facilitate inclusive experiences and instruction for a student with exceptional needs as much as possible.

5. Developing a Self-Determination and Self-Advocacy Skills

Developing a student's self-determination and self-advocacy skills enhances their own transition planning and the quality of their lives as adults in community life. This involves developing student specific outcomes in areas such as:

- decision-making
- problem solving
- taking initiative
- self-management

The family, school and other team members should help students find and use opportunities to develop and exercise self-determination and self-advocacy in their daily routines. A student may require practice in:

- expressing personal preferences and interests
- communicating wants and needs with others
- making decisions and explaining the reasons
- identifying problems or difficulties in a given situation and finding solutions
- being aware of situations that need self-advocacy (ex: discrimination, harassment, abuse, etc.), and how to deal with them
- setting goals and taking action to achieve them

6. A Comprehensive, Functional Approach

Transition planning requires a comprehensive, functional approach covering such things as vocational skills, social skills, independent living, health, daily living skills and academic knowledge. For students with limited daily living skills and difficulties in generalizing learned skills, the transition team will need to focus on developing functional skills useful to adult life in the community. Many students with exceptional needs require extensive, specific instructions and/or support to develop many of the skills others acquire through daily experiences. In addition, teaching functional skills to students with exceptional needs may be combined with community-based experiences (ex: work experience, shopping/banking skills, transportation skills) in situations where they are likely to be needed.

Meeting Preparation

Well organized meetings are essential for effective person-centred transition planning. Case managers and other team members should ensure:

- The individual student's dreams and vision for future is the standard toward which the planning team strives.
- The planning should be results-oriented with achievable goals and a plan for implementing and monitoring of outcomes.
- The focus of the planning should be on the strengths, interests and hopes of the student and the required supports, rather than on the student's disabilities.
- The planning should respect and reflect the student's background (ex: family values, way of life, culture, community life).

When, How Often and Where?

Planning meetings may be formal or informal. Informal meetings can occur as frequently as needed, anytime through the year and involve contact by phone, e-mail or in person. Formal transition planning meetings must be held at least annually. Annual outcomes need to be decided on soon after the beginning of each school year.

The time and location for meetings should be arranged by case managers to accommodate the participants as much as possible. Accessibility and convenience for the students and parents is important.

Who should attend the meeting?

A transition planning case manager should consult with the student and parents about who will be invited to the IEP/ITP meetings. The core team should include the student, parents and/or legal guardian/CFS agency worker and the case manager. The student's friends or advocates should also be welcomed to attend if their presence

will provide support and/or important information.

While many professionals and other support people (ex: teachers, administrators, specialists, community service providers, advocates, etc.) may be involved in the transition planning for the student, the team may choose to invite only the people who are directly related to the issues on the agenda to any given meeting. The case manager should consult with the student and family about who they want to invite to a meeting.

Conducting the Meeting

Planning meetings should look at priority learning needs holistically (e.g. employment, housing, personal management, health, community participation, recreation, etc.) to identify the needs of the student and co-ordinate services. The work of meeting participants may include:

- sharing new information about the student
- identifying gaps in what the team knows about a student
- developing/updating a student profile
- evaluating the progress and outcomes of previous planning or describing current levels of performance

- discussing adult support options and requirements including contacts to be made
- setting the priorities to be addressed in the plan
- identifying student specific outcomes and performance objectives
- developing implementation plans
- establishing and updating roles and responsibilities
- identifying responsibilities for writing, updating and sharing IEPs or ITPs

For a checklist outlining steps for conducting a planning meeting, see Appendix F.

Person-Centred Planning Tools

Some teams may choose to use specific person-centred planning tools for transition planning. Two tools which are commonly used are: Making Action Plans (MAPS) and Planning Alternative Tomorrows with Hope (PATH).

For further information on MAPS and PATH, see Appendix E.

Strategies for team collaboration:

- Create a positive, respectful and welcoming atmosphere.
- Avoid the use of jargon.
- Establish a joint vision and shared mission.
- Ensure every member is familiar with the purpose of the transition planning process.
- Clarify roles and responsibilities.
- Develop specific implementation plans with assigned timelines and monitor the process and results.
- Establish a communication network among members (ex: phone, e-mail, regular meetings).
- Develop agreements for collaborative teamwork and document them.

**The transition planning case manager's leadership
is particularly crucial in ensuring team collaboration**

Transition Planning Process

Transition planning may follow the same process as individual education planning (IEP). In Manitoba, IEP is a global term for any written plan developed by a team that addresses the individual needs of a student. School teams, including families, are likely to be familiar with the IEP process. What may occur, beginning in Grade 9, is that the student's IEP planning process begins to take on a new perspective with domains and student specific outcomes (SSOs) addressing transition needs taking priority as high school completion nears.

Transition planning consists of four steps consistent with individual education planning:

1. setting direction
2. gathering information
3. developing the transition plan
4. implementing and reviewing the plan

1. Setting Direction

Case managers who are responsible for transition planning will identify key team members as the first step of the process. The team members will include people who are currently involved with the student as members of the student's IEP team. The team should also include people who will be involved as the student prepares to leave school. These include community workers from Manitoba Family Services and Housing, CNIB, Society for Manitobans with Disabilities, the Canadian Paraplegic Association Inc., child and family services agencies and regional health authority programs/services. Community Service Providers and members of support networks may also have a role in individual transition planning.

Depending on the needs of the student and individual circumstances, some team members will be permanent, while others participate as needed basis or upon request.

After identifying the team members, setting direction may involve:

- orienting the members about the transition process
- clarifying member's roles and responsibilities
- deciding on a process for collaboration and sharing information

2. Gathering Information

Observation and assessment are ongoing in transition planning. They help the team monitor the student's transition needs and determine appropriate outcomes.

The team may gather information about:

- the student's vision for the future as well as interests, hopes and aptitude (with input from family and support networks when appropriate)
- background information about the student and his/her family and community (ex: language, culture, way of life, etc.)
- the student's current level of performance, experiences, strengths and needs
- the skills or knowledge the student requires for successful transition
- the available community based services and resources
- the ongoing requirements for adaptations or assistive technological devices or therapies to help the student

To gather this information, the team may:

- conduct curriculum-based assessments
- collect work samples
- interview the student, parents, teachers, or other support staff
- use inventories or checklists from the student, parents, or other support staff

- use specific observations of the student in various settings (ex: classroom, home, worksites, retail store, etc.)
- examine existing documents (ex: student school records, previous IEP or ITP assessments)
- guide the student in developing a career portfolio
- assess the student's specific skills in various real life settings (ex: vocational, behavioural, academic)
- conduct diagnostic assessments (formal or informal cognitive, or adaptive testing)

Student Self-Managed Career Portfolio Guide:

Guidelines for students in Manitoba to develop a career portfolio are available at: www.edu.gov.mb.ca/k12/cur/cardev/resources.html.

3. Develop Individual Plans

Selecting Priority Learning Needs

Successful adults try to balance their daily lives. Transition planning also requires balancing several areas:

    A. life-longlear ning

    B. employment/careerd evelopment

    C. building social networks and inclusion

    D. living in the community with independence

Although priority outcomes in transition planning may vary for individual students, the team should assure that any concerns in these areas are addressed.

For information on developing annual student specific results, see Appendix G.

A. Life-long Learning

i) Post Secondary Education

Some students may choose post secondary education after high school. Persons with disabilities have the right to reasonable accommodation within post secondary institutions. Post secondary institutions may require skills or specific prerequisites for acceptance that often demand long term preparation, such as particular course credits or skills. The transition planning team may support a student in areas such as:

- exploring the student's areas of interest, strengths and needs
- supporting self-determination and self-advocacy skills
- helping the student develop skills needed for post secondary education (ex: effective study strategies, literacy, computer skills, communication)
- learning what the entrance requirements are for post secondary institutions
- identifying disability services available in post secondary institutions
- helping the student in the application process
- arranging for assistive technical devices and investigate the portability of specialized equipment from one system of support to another

For information on post-secondary education institutes in Manitoba, see the Advanced Education and Literacy website at: www.edu.gov.mb.ca/ael/unicoll/index.html.

ii) Other Community Programs and Training Options

Students who do not choose post secondary education may benefit from other community programs or training opportunities to advance their employment or community life after graduation. The transition planning team needs to assure that the student and the family are able to access information on available community resources.

B. Employment/Career Development

Work is the key means to achieve to independence, contribute to society, develop social relationships and establish self-esteem for many citizens. For this reason this area is particularly important in transition planning for students with exceptional needs. Some students may require specific individual supports for career development. Through career development a student may:

- earn high school credits
- learn and practise pre-vocational social skills
- develop employability skills
- expand resumes and career portfolios
- make contacts with people in the business community
- adjust employment expectations, explore employment options and narrow job search focus

C. Building Social Networks and Inclusion

This area may involve developing friendships, collaborating with others and participating in social and cultural events. Areas the transition planning team may address include:

- developing social skills
  - offering and asking for help
  - negotiating conflict
- increasing social integration/networking opportunities
  - maximizing inclusive placement with peers and general public
  - exploring interests, hobbies, volunteer and leisure activities
- meeting with those who interact with the student to help them
  - understand the characteristics, strengths and needs of the student
  - communicate comfortably and successfully with the student

Career Development Curriculum

Manitoba's career development curriculum are developed by Manitoba Education Citizenship and Youth to help schools prepare students for their future careers. The following five themes included in Manitoba's life/work exploration curriculum are a guide for transition planning for all students, including those with exceptional needs:

- personal management
- career exploration
- learning and planning
- job seeking and job maintenance
- career and community experiences

D. Living in the Community with Independence

This area addresses the personal management, community participation and self-advocacy issues that an independent adult faces in the community. Examples include:

- personal management
  - daily household tasks, such as cooking, cleaning, shopping
  - personal care, hygiene
- community participation
  - voting
  - accessing community facilities, resources
- self-advocacy
  - self-awareness (strengths, weakness, specific needs)
  - awareness of potential risks and abuse and ways to prevent or deal with them

For some students, increasing independence will require specific training and supports. To be effective, the instruction and assistance should be combined with community-based experiences, in places where those skills are mostly likely to be used. Since many activities in the home environment involve these independent living skills, collaboration with home is necessary in helping the student develop and generalize necessary life skills.

4. Plan Implementation and Review

Effective implementation of the plan requires ongoing communication among the team members. Implementation also requires that S.M.A.R.T. outcomes which include practical, effective instructional and assessment strategies are in place.

SSO's should be S.M.A.R.T.

- **S**pecific: written in clear, unambiguous language
- **M**easurable: allow student achievement to be described, assessed, and evaluated
- **A**chievable: realistic for the student
- **R**elevant: meaningful for the student
- **T**ime-related: can be accomplished within a specified time period, typically one school year

The identified learning outcomes and instructional strategies are clearly understood by all team members involved on a daily basis. Implementing the plan also involves:

- securing appropriate co-operation, partnerships, resources and services to implement the plan
- maintaining ongoing communication with the student, parents, and other team members
- monitoring the progress of implementation
- revising and adapting the plan as necessary
- communicating of the progress and outcomes of the plan with team members
- reviewing and updating the plan annually

Problem Solving/Dispute Resolution

Transition planning involves a number of people working together for a common purpose. Different opinions are a natural part of working relationships. Sometimes these differences lead to disagreements or disputes. Informal dispute resolution is a co-operative, creative, problem solving process.

Working Together: A Guide to Positive Problem Solving for Schools, Families, and Communities is a resource to support local school and school division dispute resolution policies and practices.

> ***Working Together: A Guide to Positive Problem Solving for Schools, Families, and Communities* can be found at: www.edu.gov.mb.ca/k12/specedu/ problem_solving/index.html**

Appendices

INITIATING THE PROCESS **High School Entry (Age 14 to 16)**	*Age 16 to 17*	*AGE 17 to 18*	
Students and/or parents/guardians with support networks, substitute decision maker(see Appendix H), teachers,			
❑ become aware of options & planning process ❑ think about potential community experiences, graduation date, adult options ❑ provide information on strengths/ interests/ dreams	❑ explore residential support services of personal preference or plan to reside in family home ❑ understand the implications of leaving school before completing graduation requirements, or availability of adult supports	❑ at age 18 a person with disability may contact Employment & Income Assistance for assessment of eligibility ❑ apply for appropriate ID ❑ age 18 may involve move to adult residential facility with support from adult programs (ex: SLP,MH)	
School			
❑ appoint case manager for transition planning ❑ co-ordinate initial planning meeting with those closest to student (IEP team) ❑ begin appropriate work/community experiences* ❑ explore potential grad date and senior years programming direction with student, family and IEP team ❑ inform families about adult support options & transition planning process ❑ contact adult program (SLP, MH, VR) where no children's worker involved or co-ordinate contact with children's worker	❑ co-ordinate annual transition planning meeting ❑ research eligibility criteria for adult programs ❑ initiate referrals to adult programs (SLP, VR, MH) in consultation with parents ❑ include adult worker in IEP/ITP meetings ❑ assist with gathering information regarding supports required at home and in community	❑ co-ordinate annual transition planning meeting ❑ increase focus of instruction towards priority outcomes for transition ❑ advocate for establishment of community supports for adult life, where none currently exist	
* May include ongoing career development, volunteer experiences, exploration of day programming options, exposure to recreational opportunities, transportation training, skills for living in the community with independence etc.			
Services for Children			
Child and Family Service Agencies* ❑ inform the family about the transition planning process and discuss potential adult service options. (EIA, VR, etc.) and eligibility requirements ❑ complete referrals for appropriate adult services in collaboration with the parents. ❑ attend school transitional planning meetings.•	❑ complete referrals for appropriate adult services in collaboration with the family. ❑ link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility ❑ participate in school transitional planning meetings to ensure continuity of planning for services and supports	❑ continue to plan and make referrals to appropriate adult resources	
Children's Special Services, ❑ inform the family about the transition planning process and discuss potential adult service options. (EIA, VR, etc.) and eligibility requirements ❑ complete referrals for appropriate adult services in collaboration with the parents. ❑ attend school transitional planning meetings	❑ complete referrals for appropriate adult services in collaboration with the family. ❑ link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility ❑ participate in school transitional planning meetings to ensure continuity of planning for services and supports	*In consultation with adult worker* ❑ continue to plan and make referrals for required supports	
Children's Mental Health ❑ inform the family about the transition planning process and discuss potential adult service options (EIA, VR, etc.) and eligibility requirements ❑ complete referrals for appropriate adult services in collaboration with the parent/ legal guardian ❑ attend school transitional planning meetings	❑ complete referrals for appropriate adult services in collaboration with the family ❑ link the appropriate adult service worker(s) to the family, upon confirmation of program eligibility ❑ participate in school transitional planning meetings to ensure continuity of planning for services and supports	*In consultation with adult worker* ❑ continue to plan and make referrals for required supports	
Regional contacts: Children's Special Services (CSS) Phone #_____ E-mail _____ @ _____ (Other)_____ Phone #_____ E-mail _____ @ _____ _____ Phone #_____ E-mail _____ @ _____			

	One Year Before Graduation	*Graduation Year*

years where overlap may occur

siblings, relatives, friends, advocates, foster parents or group home staff

	❑ plan for post-secondary education/ training, work/community placement, or vocational/day service ❑ choose supports that match individual preferences/needs or new/ enhanced services	make informed decisions about ❑ employment ❑ move to post-secondary education/training, work/community opportunities ❑ accessing a variety of supports/services from community based service providers.
	❑ co-ordinate annual transition planning meeting ❑ increase work/community experiences ❑ ensure curriculum supports a planned move to post secondary education/training ❑ ensure completion of SLP day services: information gathering and referrals ❑ include assigned adult community worker in planning meetings ❑ identify resources required: work/community	❑ co-ordinate annual transition planning meetings ❑ increase work, community and /or recreation experiences ❑ ensure curriculum supports move to post-secondary education/ training ❑ ensure completion of SLP Day Services: information gathering and referrals ❑ include assigned Adult Community Worker in planning meetings and provide current information ❑ identify resources required: work/community
	• a child and family services agency may continue involvement beyond age 18 for children who are permanent wards under the guardianship of the CFS agency, depending on individual circumstances	

INITIATING THE PROCESS High School Entry (Age 14 to 16)	*Age 16 to 17*	*AGE 17 to 18*	

Services for Adults (Employment and Income Assistance, Supported Living Program, vocational rehabilitation services,

❑ provide transition team with general information re referral process, eligibility criteria, & adult service options

Home Care Program

❑ receive referral and conduct assessment to determine eligibility
❑ provide information on adult resources
❑ case co-ordinator collaborates in developing care plan
❑ case co-ordinator arranges services specified in care plan
❑ participate in the facilitation of alternate residential placement in community

---

Supported Living Program (SLP)

❑ acknowledge receipt of referral, check eligibility & assign community worker
❑ community worker participates in planning meetings with transition team (at least one before assuming case responsibility)
❑ provide information regarding adult supports/ service providers
❑ request for funding for residential/support services if required at age 18
❑ complete referrals to residential service provider of choice as required
❑ provide information regarding the establishment of community supports for adult life, where none currently exist

Day Services

❑ check eligibility & assign community worker
❑ provide information on adult programs and resources in community

---

Regional Health Authorities (RHA)

Mental Health (MH) Services and Supports

❑ check eligibility & assign community worker
❑ assigned worker participates in planning meetings (at least one before assuming case responsibility)
❑ provide information re adult resources
❑ complete referrals to adult resources
❑ request for funding for residential and/or support services if required at age 18

Home Care Program

❑ assess and facilitate request for funding for residential/support services if appropriate at age 18

Regional Community Workers:

Name _____

E-mail _____

Phone _____

Address _____

Name _____

E-mail _____

Phone _____

Address _____

Regional contacts

RHA Contact Information:

Name _____ Phone #_____

E-mail _____ @ _____

Community Mental Health

Name _____ Phone #_____

E-mail _____ @ _____

Supported Living Program

Name _____ Phone #_____

E-mail _____ @ _____

Employment and Income Assistance

Name _____ Phone #_____

E-mail _____ @ _____

Vocational Rehabilitation Program

Name _____ Phone #_____

E-mail _____ @ _____

Other

Name _____ Phone #_____

E-mail _____ @ _____

	One year Before Graduation	*Graduation Year*

mental health services and supports, Home Care Program)

Employment and Income Assistance
❑ apply in person at age 18 and beyond

Regional Office Address: _____

Phone #_____

Vocational Rehabilitation Program FSH, RHA, designated agency (SMD, CNIB, CPA)
❑ acknowledge receipt of referral, check eligibility & assign community worker
❑ community worker participates in meetings with transition team
❑ provide information on adult supports/ service providers
❑ develop individual vocational plan
❑ identify and initiate referral to service provider of choice and request funding for services, including technical assessments, upon student leaving school

Regional Vocational Rehabilitation community workers:

Name _____ Phone #_____ E-mail _____ @ _____

Name _____ Phone #_____ E-mail _____ @ _____

Name _____ Phone #_____ E-mail _____ @ _____

Designated Agency Contacts:

Name _____ Phone #_____ E-mail _____ @ _____

Name _____ Phone #_____ E-mail _____ @ _____

Name _____ Phone #_____ E-mail _____ @ _____

Supported Living Program (SLP) – Day Services
❑ ensure completion of previous steps in the referral process
❑ community worker participates in meetings
❑ request funding for day service resources two years before graduation
❑ referrals to day service resources and adult clinical services

Name _____ Phone #_____ E-mail _____ @ _____

Name _____ Phone #_____ E-mail _____ @ _____

Name _____ Phone #_____ E-mail _____ @ _____

APPENDIX B

Transfer of a pupil file and continuation of transition planning when a student changes schools or school divisions.

A pupil file and the pupil support file will contain information important for the transition planning team including a copy of the latest individual plan for the student. When a student transfers to another high school there is an expectation that transition planning will be carried on by the new team and the plan will be adjusted as necessary.

A student's pupil file and pupil support file will typically include:

- information on the student's citizenship and legal entitlement to work in Canada
- the most recent individual education plan (IEP) and/or health care plan specifically devised for the student and any amendments
- current notes on referrals to/contacts with external agencies (ex: child and family services) or caregivers
- detailed documentation from school clinicians and special education/resource staff about all inter-agency contacts and services
- ongoing health/psycho-social/counselling information, whether medical, psychological or behavioural
- the results of special diagnostic tests
- reports from service providers such as agencies, hospitals and clinics
- any other assessment or evaluations the parents/legal guardians or the student wants placed in the file

Transition Case Checklists

Transition Checklist - High School Entry - Age 14 to 16

	Name	Phone #
Student		
Parent		
Legal Guardian		
Case Manager (Transition)		
Children's Program Contact		
Community Worker		

School

Date Initiated	Complete	Not Applicable	
			Identify case manager for transition planning.
			Provide general information to students, parents or legal guardian about adult options and planning process.
			Co-ordinate initial planning with those closest to student (IEP team).
			Introduce community experiences.
			Explore potential graduation date and high school programming direction with students, parents or legal guardians and IEP team.
			Make initial contacts with adult programs (SLP, MH, VR, Home Care) if no children's worker is involved or co-ordinate contact with children's worker.
			Initiate referrals to SLP, VR and Home Care if appropriate.

Student - With help from the Support Network

Date Initiated	Complete	Not Applicable	
			Become aware of options and planning process.
			Think about potential for
			❑ community experiences
			❑ graduation date
			❑ for adult options available
			❑ to share information on strengths/interests/dreams

Transition Checklist - Age 16 to 17

	Name	Phone #
Student		
Parent		
Legal Guardian		
Case Manager (Transition)		
Children's Program Contact		
Community Worker		

School

Date Initiated	Complete	Not Applicable	
			Identify case manager for transition planning.
			Co-ordinate annual transition planning meetings.
			Gather information on supports required at home and in community..
			Review eligibility criteria for adult programs.
			Include assigned adult community worker in planning meetings.
			Make initial contacts with adult programs (SLP, MH, VR, Home Care) if no children's worker is involved or co-ordinate contact with children's worker.
			Increase community (work and/or recreation) experiences.
			Ensure curriculum supports a planned move to post secondary education/training.
			Identify resources required (work/community).
			Gather information and initiate referral to Supported Living Program.
			Initiate referrals to Community Mental Health if appropriate.

Student - With help from the Support Network

Date Initiated	Complete	Not Applicable	
			Choose residential support services of personal preference or plan to reside in family home.
			Understand the implications of leaving school before completion of graduation requirements, or availability of adult supports.
			Plan for post-secondary education/ training, work/community placement or vocational/day services.
			Choose supports that match individual preferences/needs or advocate for new/enhanced services.

Transition Checklist - Age 17 to Graduation

	Name	Phone #
Student		
Parent		
Legal Guardian		
Case Manager (Transition)		
Children's Program Contact		
Community Worker		

School

Date Initiated	Complete	Not Applicable	
			Identify case manager for transition planning.
			Co-ordinate annual transition planning meetings.
			Increase focus of instruction towards priority outcomes for transition.
			Help determine appropriate community options for adult life.
			Include assigned community worker in planning meetings.
			Provide information on the student's current performance and needs, including clinical (OT, PT SLP, Nutrition), to assigned community worker.
			Ensure graduation requirements have been met.
			Initiate long-term work/ community experiences and investigate continuity post graduation in collaboration with community worker and support network.

Student - With help from the Support Network

Date Initiated	Complete	Not Applicable	
			If student is 18 or older, contact Employment and Income Assistance for persons with disabilities for assessment of eligibility.
			Make informed decisions about: ❑ employment options ❑ move to post secondary education/training, work/community opportunities ❑ accessing supports/services from community based service providers
			Choose adult community based supports or service provider from available options.
			Apply for appropriate identification.

Appropriate Educational Programming

Students are eligible to attend school until they graduate or until June of the calendar year in which they turn 21, whichever comes first. Appropriate educational programming is determined by the school team in collaboration with the student and parents/legal guardians through the individual education planning (IEP) process. The direction of programming is determined by the student's profile of need.

> **This programming and planning is directed by The Public Schools Act, Appropriate Educational Programming in Manitoba: Standards for Student Services, and several supporting documents and guidelines. They can be found at: www.edu.gov.mb.ca/k12/specedu/aep/index.html.**

Potential Programming Directions Include:

Adaptations

Adaptation is the act of making changes in the teaching process, assessment process, instructional materials, or student products. These include, but are not limited to, changes to the physical environment, social environment, presentations, tests and assessments, assignments and projects, organizational supports, time required to achieve provincial outcomes. Adaptations are used when students with exceptional learning needs are able to meet the same learning outcomes as their peers, through adaptations such as those listed above.

Modification / Modified (M) Course Designation

Students who have exceptional needs may benefit from participating in the learning opportunities offered in grades 9 to grade12 courses. If students have significant cognitive disabilities that do not allow them to meet the Manitoba curriculum outcomes, even with supports, the school team determines that these students' courses will be modified and they will receive a Modified (M) course designation. It is important that students and parents are included in this decision. The (M) course designation is applied on an individual course basis to those courses developed or approved by Manitoba Education Citizenship and Youth. Modification means that the number or content of the Manitoba curriculum outcomes are changed to meet a student's cognitive learning needs. Modifications need to be outlined in an IEP and identified on a student's report card. Students in Grade 9 to Grade 12 receive a percentage mark according to their achievement of the modified curriculum.

> **For more information, see to Towards Inclusion: A Handbook for Modified Course Designation, Senior 1-4 at: www.edu.gov.mb.ca/k12/sepcedu/modified/index.html.**

Individualized Programming/Individualized Programming Designation

Some students' cognitive disabilities are so severe that they require learning outcomes that are individualized and different than the Manitoba curricular outcomes. These students need appropriate educational programming based on highly individualized and, functional student-specific outcomes within age-appropriate school and community environments. A team that includes parents makes the decision to provide individualized programming based on the student's cognitive ability. The student's specific outcomes or goals should be outlined in an IEP. Students receiving an individualized programming designation in high school do not use Manitoba Education, Citizenship and Youth curriculum. Individualized programming often includes vocational and transition planning for life after school. The Individualized (I) programming designation is not course specific but identifies a full year of individualized programming. Students do not receive marks; their progress is documented through the IEP process.

Note: students can participate in the modified course designations (M) or individualized designations (I), but not both.

> For additional information on individualized programming, see Towards Inclusion: A Handbook for Individualized (I) Programming Designation, Senior Years at: www.edu.gov.mb.ca/k12/specedu/individu/index.html.

High School Graduation

Opportunities are available for students (including those with significant cognitive disabilities) to choose courses that are of interest to them. High school students earn credits for compulsory and optional courses, locally developed courses, distance education courses, post secondary courses (college and university) and others such as community service. Students who have completed the required number of compulsory and optional courses, including (M) course designations, receive a Manitoba high school diploma.

> For more information on graduation requirements in Manitoba see:
> www.edu.gov.mb.ca/k12/policy/grad_require.html.

> **Certificate of Completion for Students Receiving Individualized Programming Designation**
>
> In March 2007, Manitoba Education, Citizenship and Youth introduced a certificate of completion for an Individualized Senior Years program, effective in the 2006 to 2007 school year. This certificate recognizes the achievement of students with significant cognitive disabilities who benefit from a highly individualized, functionally appropriate learning experience.
>
> Information guidelines for awarding the certificate are available at
> www.edu.gov.mb.ca/k12/policy/grad_require.html.
>
> Certificates of completion can be ordered through the Manitoba Text Book Bureau at www.mtbb.mb.ca/, stock #72501.

APPENDIX E

Person-Centred Planning Tools

Making Action Plans (MAPS)

MAPS was developed by Marsha Forest and is based on 24-Hour planning by Karen Green McGowan. The framework of MAPS:

1. What is the history of the student? The student and the family are given opportunities to tell the team what the student's life has been like.
2. What are the dreams of the student? The student (and his/her support network, if necessary) is asked to describe the dreams or visions of the student.
3. What are the potential nightmares or overriding issues? The team brainstorm on what will happen if they do not work together to make change or leave things as they are?
4. Who is the student? The student and the team establish a detailed understanding of the individual.
5. What are the student's strengths, gifts, and talents?
6. What are the student's needs?
7. What is the plan of action? What are the goals, steps or supports required to achieve the goals?

Planning Alternative Tomorrows with Hope (PATH)

PATH was developed by John O'Brien, Marsha Forest and Jack Pierpoint of Inclusion Press. The PATH process involves the following:

1. Identifying dreams and values of the student
2. Setting positive and achievable goals, based on the identified dreams of the student
3. Identifying the current capacity of the student, the resources available and the gap between present needs and desirable goals
4. Identifying people to enroll who can help achieve the goals
5. Recognizing ways to build strength through services or resources
6. Charting action for the next few months
7. Planning the next month's action
8. Committing to the first step

For Further information visit:
Inclusion Press at www.inclusion.com

Conducting a Planning Meeting

Before the meeting:

- ❏ send an agenda to the potential participants
- ❏ indicate time and place of meeting
- ❏ assign a meeting facilitator (may or may not be the case manager)
- ❏ preview the agenda, process, and expected attendants of the meeting with the student and parents and discuss concerns or issues that they would like to raise

During the meeting:

- ❏ introduce everyone present, when necessary, and their roles
- ❏ state the purpose of the meeting and its expected time limits
- ❏ review the agenda and make changes as required
- ❏ assign a recorder
- ❏ focus on person-centred and outcome-oriented planning
- ❏ move through and discuss the agenda items
- ❏ discuss implementation plans and clarify members' responsibilities, timeline, achievement criteria for each plan
- ❏ summarize the discussion and decisions of the meeting
- ❏ set time and location for the next meeting

Follow-up of the meeting:

- ❏ distribute the minute of the previous meeting and the agenda for the next meeting
- ❏ discuss the minutes of the meeting with the student and/or parent, if necessary
- ❏ maintain contact with team members for problem-solving and follow-up on progress of performance objectives and student specific outcomes

Adapted from: *Individual Education Planning: A Handbook for Developing and Implementing IEPs Early to Senior Years, Manitoba Education Training and Youth, 1998*

APPENDIX G

Annual Student Specific Outcomes:

A manageable plan will summarize only the team's highest priorities for the school year within categories called domains. Student Specific Outcomes (SSOs) may be developed to address specific areas in each domain:

- While the plan will not outline all the teaching and learning experiences of the student during the school year, it will describe the highest priority outcomes that the team will measure and expect the student to achieve during the school year

Student Specific Outcomes may stem from priority learning needs such as life-long education and training, employment/career development, building social relationships and networks and/or living with independence in the community

SSOs should:

- Be derived from the student's current level of performance.
- Take into consideration the students past achievement and rate of progress.
- Challenge the student but be achievable.
- Be relevant to the student's needs.
- Focus on what the student will do, rather that what he or she will stop doing.
- Be achievable with respect to the instructional time and resources available.

SSO's should be S.M.A.R.T.

- **S**pecific: written in clear, unambiguous language
- **M**easurable: allow student achievement to be described, assessed, and evaluated
- **A**chievable: realistic for the student
- **R**elevant: meaningful for the student
- **T**ime-related: can be accomplished within a specified time period, typically one school year

In addition, the outcomes should specify the conditions (ex: assistive technology device, environment and level of assistance) and the criteria (ex: frequency and degree of completion) under which they are to be achieved.

Legislation Affecting Transition Planning Teams

The Manitoba Human Rights Code

The Manitoba Human Rights Code prohibits unreasonable discrimination arising from a person's actual or perceived physical or mental disability.
For more information visit: www.gov.mb.ca/hrc/english/publications/factsheets/p-disab.html.

Vulnerable Persons Living with Mental Disability Act

The act reflects the right of all people to make their own decisions and to have help when necessary in a manner that respects their independence, privacy and dignity. Substitute decision making is described in this act.
For more information visit: www.gov.mb.ca/fs/pwd/vpact.html.

The Healthy Child Manitoba Act

The purpose of this act is to guide the development, implementation and evaluation of the Healthy Child Manitoba strategy in the government and in Manitoba communities generally. The act continues the Healthy Child Committee of Cabinet, unique in Canada, ensuring the on-going leadership of all ministers whose portfolios or departments directly affect the lives of children.
For more information visit: web2.gov.mb.ca/laws/statutes/ccsm/h037e.php.

The Protection for Persons in Care Act

The act helps protect adults from abuse while receiving care in personal care homes, hospitals or any other designated health facility.
For more information visit: www.gov.mb.ca/health/protection/.

Appropriate Educational Programming in Manitoba: Standards for Student Services

Appropriate Educational Programming in Manitoba: Standards for Student Services embodies the spirit of human rights legislation and regulations, elaborates on the education regulations and establishes standards for school divisions. The standards provide school divisions with a framework to use in developing a local policy for appropriate educational programming.
For more information visit: www.edu.gov.mb.ca/k12/specedu/aep/index.html.

The Child and Family Services Act

The Child and Family Services Act outlines the fundamental principles guiding the provision of services to children and families in Manitoba.
For more information visit: web2.gov.mb.ca/laws/statutes/ccsm/c080e.php.

The Child and Family Services Authorities Act

The purpose of the Child and Family Services Authorities Act is to establish authorities that are responsible for administering and providing for the delivery of child and family services in Manitoba. **For more information visit: web2.gov.mb.ca/laws/statutes/2002/c03502e.php.**

The Personal Health Information Act

The purpose of the Personal Health Information Act (PHIA) and the related Freedom of Information and Protection of Privacy Act (FIPPA) is to provide individuals with a right to examine and receive a copy of personal health information about themselves, to control the manner in which personal health information is collected and the right to request corrections to personal health information about themselves. This act also protects individuals against the unauthorized use of personal health information.
For more information visit: www.gov.mb.ca/health/phia/links.html.

The Youth Criminal Justice Act (Canada)

The Youth Criminal Justice Act (YCJA) deals with records and information of youth who have been dealt with under the act. Statutes such as the Public Schools Act, the Educational Administration Act, FIPPA and PHIA do not apply to youth criminal justice information. The YCJA permits limited disclosure of information in records kept under this act and youth criminal justice information must be handled in accordance with the YCJA even when it is included as part of a pupil file or some other record.
For more information visit: www.justice.gc.ca