

Youth's Name: _____

Describe any safety related concerns.

Are there any transportation issues? How will the youth get to life skills classes?

Does the youth have any behavioral/emotional problems? Include clinical diagnosis and medications, if applicable.

What level of assessment was used? I II III IV

What was the rationale for choosing this assessment?

Were any supplemental assessments completed? Yes No

If yes, which assessments were completed?

What is the youth's learning style? Auditory Visual Participatory

Does the youth have a physical disability? Yes No

Type of disability: _____

Date Received: _____ Approved: Yes No Pended: Yes No

Assigned Provider:

Signature of Transition Manager: