

**NYS Office of Addiction Services and Supports
Element Transition
For Use By Part 820 Residential Programs Only**

Provider Number _____ Program Number _____

Client Information					Transition Information			LOCADTR Information	
Client ID	Sex (at birth)	Birth Date (____/____/____)	Last 4 SSN	Last Name First 2 Letters (at birth)	Transaction Date (____/____/____)	To Element of Care	To Reintegration Setting	Assessment ID	Created Date (____/____/____)
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X					<input type="checkbox"/> Stabilization <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Reintegration	<input type="checkbox"/> Congregate <input type="checkbox"/> Scatter-Site		
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X					<input type="checkbox"/> Stabilization <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Reintegration	<input type="checkbox"/> Congregate <input type="checkbox"/> Scatter-Site		
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X					<input type="checkbox"/> Stabilization <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Reintegration	<input type="checkbox"/> Congregate <input type="checkbox"/> Scatter-Site		
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X					<input type="checkbox"/> Stabilization <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Reintegration	<input type="checkbox"/> Congregate <input type="checkbox"/> Scatter-Site		
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