Reset Form

California Community Transitions (CCT) Enrollee Information Form

CCT Lead Organization

Form Completed by

Date of Admission to the Facility

Transition anticipated to occur within:

1 – 59 Days

60 Days +

Medi-Cal Member's Information:

1. First Name
2. Last Name
3. Date of Birth
4. Client Index Number (CIN)
5. Was this member referred to your organization because of his/her response to Minimum Data Set (MDS) Section Q? Yes No
6. Target Population (Select all that apply)

   Elderly

   Physical Disability

   Mental Illness

   Developmental Disability

Member's Name:

7. Does the member have a Legal Guardian/Conservator? ◯ Yes ◯ No

*If "**Yes**," complete questions 7a.*

*If "**No**," go to question 8.*

7a. Legal Guardian/Conservator's Name

Legal Guardian/Conservator's Phone Number

8. Is the member enrolled in a managed care plan? ● Yes ● No

*If "**Yes**," complete question 8a.*

*If "**No**," go to question 9.*

8a. Did the member's managed care plan refer him/her to your organization? ◯ Yes ◯ No

9. Does the member reside in a Coordinated Care Initiative (CCI) County?

● Yes ◯ No

10. Is the member dually eligible for both Medi-Cal and Medicare?

● Yes ◯ No

11. In which of the following qualified institutions does the member reside?

● Inpatient Psychiatric Hospital / Institution for Mental Diseases (IMD)

◯ Inpatient Facility (Please identify the type(s) below)

☐ Hospital ☐ Sub-acute Care

☐ Nursing Home ☐ Rehabilitation

Member's Name:

12. Name of the Facility

13. Facility's Physical Address

Street

City State

Zip Code

14. Contact at the Facility

Contact's Name

Contact's Title

Contact's Phone Number

15. Member's Primary Care Physician (PCP)

PCP's Name

PCP's Phone Number

16. Has the member continuously resided in an inpatient facility for at least 60 days or longer, not including days (s)he was in the institution for the sole purpose of receiving short-term rehabilitation services that are reimbursed under Medicare?

● Yes ○ No

17. Has the member received Medi-Cal benefits for inpatient services in a qualified institution, for at least one (1) day? ● Yes ○ No

Member's Name:

18. Has the member ever been enrolled in CCT in the past? ● Yes ○ No

*If "**Yes**," go to question 19 a.*

*If "**No**," skip to the final statement at the bottom of this page.*

19 a. Did the former CCT Enrollee transition to the community in the past?

● Yes ● No

*If "**Yes**," go to question 19 a-1.*

*If "**No**," go to question 19 a-2. and 19 a-3.*

19 a-1. Did the former CCT Participant complete the entire 365-day period of participation? ● Yes ○ No

Note: LOs must submit a *Request to Re-enroll a Former CCT Participant* form to be considered for re-enrollment after completing the 365-day period of participation.

19 a-2. If "No," what was the reason for discontinuation?

19 a-3. What was the previous date of discontinuation?

Date the Medi-Cal member, or his/her legal representative,signed the CCT Rights and Responsibilities/Consent Form

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By submitting this form, the CCT Lead Organization (LO) certifies that this member is eligible to enroll in CCT based on the federal requirements identified in the CCT LO Agreement.