Last Rev: 7-21-16

Clear Form

California Community Transitions (CCT)
Day of Transition Report Form

CCT Lead Organization	
Form Submitted by	
Date Submitted	

Participant Instructions – Please review this form **very** carefully. Be sure to speak with your transition coordinator if you have questions about the information in this form **before** you provide your signature.

Participant's Information

Name (*First, M., Last*)

Phone Number

Medi-Cal Number Date of Birth

If applicable, please provide the following for the Participant's Legal Representative:

Name (*First, M., Last*)

Phone Number

_ _ _ *This section is to be completed by the Participant / Participant's Legal Guardian* _ _ _

Date of the Transition (*Today's Date*)

Are all of the services and supports approved in your Final CCT Transition and Care Plan in place at this time?

- ◯ **Yes** If Yes, please initial here to confirm: _____
- ◯ **No** If no, on what date are the approved support(s) and/or service(s) scheduled to be in place?

By signing this form, I _____ confirm that BOTH of the following statements are true:

1. My Transition Coordinator is with me today, the day of my transition to the community.
2. My 24-hour Back-up Plan is posted in an accessible location near the telephone.

_____ _____

Participant's (or Legal Representative's) Signature Date

_ _ _ This page is to be completed by the Transition Coordinator _ _ _

Type of Transition ◯ CCT ◯ Non-CCT

Home Address

Type of Housing

◯ Home, owned by the Participant ◯ Home, owned by a Family Member

◯ Apartment – not assisted living ◯ Apartment – assisted living

◯ Group Home (only applies to community care facilities with 4 or fewer unrelated residents)

Is the Participant living with family? ◯ Yes ◯ No

Is the Participant enrolled in a Managed Care Plan? ◯ Yes ◯ No

If Yes, please identify the MCP

If No, when is the Participant expected to be enrolled in a MCP?

◯ Within 1 week ◯ Beyond 1 month

◯ Within 1 month ◯ Participant chooses not to enroll

Please identify the MCP into which the Participant is expected to enroll

This section should only be completed for Participants transitioning into a **Coordinated Care Initiative (CCI)** County.

In which long-term care services health plan option is the Participant enrolled?

◯ Cal-MediConnect ◯ MLTSS

Which Home and Community-based Services will the Participant receive?

☐ AIDS Waiver

☐ Assisted Living Waiver (ALW)

☐ In-home Support Services (IHSS)

☐ Multi-purpose Senior Services Program (MSSP)

☐ Nursing Facility or Acute Hospital (NF/AH) Waiver

☐ Pediatric Palliative Care (PPC)

☐ Program of All-inclusive Care for the Elderly (PACE)

☐ Senior Care Action Network (SCAN)

☐ None of the HCBS listed here*

* If "None," list the supports and services the Participant will receive:

Target Population (select all that apply)

☐ Elderly (65+) ☐ Physically Disabled ☐ Mentally Ill ☐ Developmentally Disabled