

**California Community Transitions (CCT)  
Final Transition and Care Plan**

CCT Lead Organization

Form Completed by

Enrollee's Legal Name

Medi-Cal Number

Date of Birth

Date of Scheduled Transition

List key changes since assessment and initial transition and care plan:

Hospitalizations or emergency room visits:

Secured housing arrangement:

Return to own home

Alone

With family

With others

Independent housing (including public housing)

Alone

With others

Group home or residential care facility (non-ALW)

Residential care facility (ALW)

Public housing (ALW)

*Member's Name:*

Based on the member's ANTICIPATED Maintenance Need Level (MNL) for living and receiving services in the community, what is his/her ESTIMATED Share of Cost upon discharge from the facility? \$

Post-transition Care Plan - Health Care Services (check all that apply):

Managed care health plan

Nursing home or acute hospital (NF/AH) waiver. Level:

In-home support services (IHSS). Number of authorized hours:

AIDS waiver

Multi-purpose senior services program (MSSP)

SCAN

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

Cal Medi-Connect

Assisted living waiver (ALW)

DD waiver

Pediatric palliative care (PPC)

Supportive services (check all that apply), provide names and phone numbers:

ILC or peer support

Name

Phone

Family members

Name

Phone

Friends or neighbors

Name

Phone

Others

Name

Phone

DME set up and in place before transition (check all that apply):

Power wheelchair

Manual wheelchair

Grab bars

Hand held shower nozzle

Bedside commode

Other (please list below)

*Member's Name:*

Health care providers (select all that apply), provide names and phone numbers:

Home health agency

Name

Phone

Behavioral health services

Name

Phone

Mental health services

Name

Phone

Substance use prevention services

Name

Phone

IHSS approved and in place

Yes

Awaiting assessment

No

Hours approved, caregiver not hired yet

Not applicable

Caregivers

Name

Phone

Relationship

Name

Phone

Relationship

Household Set-Up completed before transition (check all that apply):

YES

NO

N/A

If no, explain what is left to accomplish:

Home Modifications completed before transition (check all that apply):

YES

NO

N/A

If no, explain what is left to accomplish:

*Member's Name:*

Vehicle Adaptation completed before transition (check all that apply):

YES                      NO                      N/A

If no, explain what is left to accomplish:

Risk Assessment:

List potential areas of concern or issues which need to be addressed prior to enrollee's/participant's transition. For example, a history of substance use (alcohol or drugs), minimal family support, risk of re-institutionalization, etc.

Common Areas of Concern (check all that apply):

Re-institutionalization

Homelessness

Isolation

Substance Use

Other (explain):

RISK #1:

Steps taken to prevent or mitigate re-occurrence of problem:

RISK #2:

Steps taken to prevent or mitigate re-occurrence of problem:

RISK #3:

Steps taken to prevent or mitigate re-occurrence of problem:

*Member's Name:*

Additional Information not included elsewhere:

Signatures of Persons Completing this Final Transition and Care Plan (F-TCP)

\_\_\_\_\_  
Transition Coordinator (TC) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
CCT Enrollee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Representative or Conservator's Signature  
(if applicable)

\_\_\_\_\_  
Date

**Date of Scheduled Community Physician Intake Appointment:**

Community-based Primary Care Physician:

Name:

Phone:

Address:

See NEXT PAGE for Health Care Service Plan

Member's Name:

Health Care Service Plan (HCSP)  
DHCS Home and Community-Based Services (HCBS) Waiver Summary

**ALW**

Current Tier

Previous Tier

ALW Residence

HCSP (check all that apply)

Initial

Semi-Annual

Yearly

Update

Reason:

Date of last HCSP

**NF/AH**

Level of Care

IHO Office (check all that apply)

North

South

Intake Nurse

Case Manager

Completion Date (mm/dd/yyyy)

This plan should include all health care diagnoses of record, with dates of occurrences for major diagnoses; physical, mental, and behavioral challenges/limitations; and safety and socialization issues.

Health problem #1

Interventions

Goal of intervention

Responsible provider

Health problem #2

Interventions

Goal of intervention

Responsible provider

*Member's Name:*

Health problem #3

Interventions

Goal of intervention

Responsible provider

Health problem #4

Interventions

Goal of intervention

Responsible provider

Health problem #5

Interventions

Goal of intervention

Responsible provider

Health problem #6

Interventions

Goal of intervention

Responsible provider

Health problem #7

Interventions

Goal of intervention

Responsible provider

Health problem #8

Interventions

Goal of intervention

Responsible provider

*Member's Name:*

Health problem #9

Interventions

Goal of intervention

Responsible provider

Health problem #10

Interventions

Goal of intervention

Responsible provider

Health problem #11

Interventions

Goal of intervention

Responsible provider

Health problem #12

Interventions

Goal of intervention

Responsible provider

Signature of person completing the health care service plan (HCSP).

---

Registered Nurse (RN) Signature

---

Date