

## **California Community Transitions (CCT) Initial Transition and Care Plan**

CCT Lead Organization:

Form Completed by:

Enrollee's Legal Name:

Medi-Cal Number:

Date of Birth:

Targeted Date of Transition:

Preferred Housing Option:

Return to Own Home

Alone

With Family

With Others

Independent Housing (including public housing)

Alone

With Others

Group Home / Residential Care Facility (non-ALW)

Residential Care Facility (ALW)

Public Housing (ALW)

Anticipated Plans for Care:

Intervention

Goal of Intervention

Proposed Provider

Medical Care

Intervention

Goal of Intervention

Proposed Provider

On-going

Nursing Care

*Member's Name:*

	Intervention	Goal of Intervention	Proposed Provider
Personal Care Needs			

	Intervention	Goal of Intervention	Proposed Provider
On-going Supervision			

	Intervention	Goal of Intervention	Proposed Provider
Therapies			

	Intervention	Goal of Intervention	Proposed Provider
Mental Health Care			

	Intervention	Goal of Intervention	Proposed Provider
Substance Abuse			

Member's Name:

Intervention	Goal of Intervention	Proposed Provider
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On-going Case Management

Intervention	Goal of Intervention	Proposed Provider
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On-going Habilitation

Intervention	Goal of Intervention	Proposed Provider
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Social Reintegration

Intervention	Goal of Intervention	Proposed Provider
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Other

Durable Medical Equipment (DME):

What type(s) of DME will be required outside of the inpatient facility?  
(check all that apply):

Power Wheelchair

Manual Wheelchair

Grab Bars

Bedside Commode

Shower Chair

Hand-held Shower Nozzle

Other (please list)

*Member's Name:*

Environmental Services:

What type(s) of Home & Vehicle Modifications, Assistive Technology, and/or Household Set-Up will be required outside of an inpatient facility?

Home Modification(s)  
(please list):

Vehicle Adaptation(s)  
(please list):

Assistive Device(s)  
(please list):

Home Set-up:

Already has supplies

Supplies need to be purchased

What is the member's current Share of Cost (SOC) in the facility? \$

Key Continuity of Care Issues:

*Member's Name:*

**Risk Assessment:**

List potential areas of concern or issues which need to be addressed prior to enrollee's/participant's transition.

Examples: 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

**RISK #1:**

Steps to be taken to prevent or mitigate occurrence of problem:

**RISK #2:**

Steps to be taken to prevent or mitigate occurrence of problem:

**RISK #3:**

Steps to be taken to prevent or mitigate occurrence of problem:

*Member's Name:*

Additional information not included elsewhere:

**Select one of the two options below, read it, and if it is correct, sign.**

**Option 1:**

The Initial Transition and Care Plan developed for this individual does not sufficiently address his/her medical needs as identified in the CCT Clinical Assessment at this time.

By signing below, I understand that the CCT transition process cannot move forward until an Initial Transition and Care Plan has been developed that addresses all of the individual's medical needs, as identified in the CCT Clinical Assessment, in the community.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

