Community Transitions Factsheet

Name:			Address:			CT Date:			
Phone:	H		W		Date of Birth:		Med. ID		
Program Type:		EPD		SP	Start Date:		End Date:		
Legal Guardian		Self		Other (explain):					
Emergency Contacts:	1.						Phone:		
	2.						Phone:		
Physician:							Phone:		
Healthcare Decision Support		1.					Phone:		
		2.					Phone:		

Meeting Notes (describe identified transition support needs)	
Case Management:	
Personal Care Aide Services:	
Waiver Service (Other):	
Waiver Service (Other):	
Waiver Service (Other):	
Non-Waiver Service(s)	
Skilled Care Supports:	
Y N	
Behavioral Health Supports:	
Y N	

Discharge/Community Transition Team Consensus (check the applicable box to indicate approval)

	Beneficiary/AR/Guardian		DHCF		DACL/CTT		HHA
	Nursing Facility		Case Management		Other		Other

Service Type/	Start Date	Agency/Address	Contact/Position
Case Management:			
PCA:			
Other:			
Other:			
Other:			

DHCF/DACL Use Only

Completed/Updated by:		Agency		Date:	

V.9.1.24