COLORADO CHOICE TRANSITIONS
YOUR PATH TO INDEPENDENCE

HOME & COMMUNITY BASED SERVICES HCBS ELDERLY, BLIND AND DISABLED EBD

Community Transition Report

Client Name: _____

Medicaid #: _____ Non-Medicaid: _____

Transition Coordination Agency: _____ Transition Coordinator Name: _____

Nursing Facility: _____

Transition Assessment Date: _____ Facility Discharge Date: _____ Final Home Visit: _____

Type of Transition: ____Community Transition Services (CTS) ____Colorado Choice Transitions (CCT) ____Other

Transition Team Members

❑ Family/Significant Other	❑ Guardian	❑ Housing Coordinator
❑ Nursing Facility	❑ Mental Health Provider	❑ Nurse
❑ Community Centered Board	❑ Area Agency on Aging	❑ Physician
❑ Ombudsman	❑ Other ILC Staff	❑

Transition Location

❑ Independent Apartment	❑ Alternative Care Facility	❑ Family
❑ Assisted Living Facility	❑ Residential Group Home	❑ CCT Qualified Residence

Community Transition Funds accessed for:

❑ Security Deposit	❑ Set-up Fee	❑
❑ Household Items	❑ Furnishings	❑
❑ Moving Expenses	❑ Food	❑
❑ Health & Safety Assurances	❑ Home Modification	❑

Community Supports in Place

❑ Single Entry Point	❑ Home Health Care	❑ Home Modification
❑ Mental Health Provider	❑ Family	❑ Spiritual Community
❑ Community Centered Board	❑ Personal Care	❑
❑ Adult Day Services	❑ Homemaker	❑
❑ Respite	❑ Electronic Monitoring	❑

Site Visit Status

Visit	Client Status	Concerns/Complaints/Issues	Resolution
Prior to discharge			
Day of move			
1 week post discharge			
1 month post discharge			

SEP Case Manager Name: _____ Telephone: _____

E-Mail Address: _____

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