Targeted Case Management -Transition Coordination (TCM-TC) Community Transition Plan

Member _____ Date _____

Transition Coordinator _____

Housing

Preferred Housing	Roommate Preferred	Voucher Needed	Security Deposit Needed	First Month's Rent Needed	Housing Confirmed
Previous Residence					
Independent Apt					
Assisted Living					
Host Home					
Family Residence					
Other					

Home Modification

Modification Needed	Assessed Need	Provider (if known)	Needed Prior to Move In	Service Initiation Date

Home and Community-Based Services (HCBS)

Service	Critical Service	Frequency Schedule	Person Responsible for Referral	Preferred Provider Identified by Member

Physical and Behavioral Health Care Services

Service	Critical Service	Frequency and Schedule	Person Responsible for Referral	Preferred Provider Identified by Member

Assistive Technology and Durable Medical Equipment

Device/Equipment	Dr. Orders Obtained	Needed prior to move-in	Person Responsible for Referral	Preferred Provider Identified by Member

Household Set-Up

Item/Resource	Needed prior to move-in	Person Responsible for Assisting Member with Acquisition	Acquisition Date

Community Supportive Services

Service/Resource	Needed prior to move-in	Person Responsible for Assisting Member with Acquisition	Acquisition Date
LEAP			
Bus Pass			
Faith community			
Volunteer opportunity			
Food Stamps			
Other			

Member Life Goals for Next Six Months
