Returning California Community Transitions (CCT)
Lead Organization (LO) Information

(Read the instructions fully prior to completing this form)

Date of Form Completion: _____ ☐ New ☐ Revised

Is organization enrolled in Medi-Cal? ☐ Yes ☐ No

National Provider Identification (NPI) Number: _____

Provider Type: _____

Legal Identification

Legal Entity Name: _____

Program/Facility Name: _____

Federal Tax Identification Number: _____

Type of Organization: _____

Authorized Signatory's Name: _____

Authorized Signatory's Title: _____

Facility/Business Address

Street: _____

P.O. Box: _____

City: _____

Zip Code: _____

Administrative/Corporate Address

Street: _____

P.O. Box: _____

City: _____

Zip Code: _____

Mailing Address

Street: _____

P.O. Box: _____

City: _____

Zip Code: _____

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GENERAL

The DHCS California Community Transitions (CCT) Lead Organization (LO) form is required for all community organizations interested in returning to CCT LO status. If the organization has not provided transition coordination within **the prior 365** days, a returning CCT LO Information form is required. This form is required to ensure DHCS has current information, as well as, ensure the CCT LO is enrolled in Medi-Cal prior to beginning transition services.

INSTRUCTIONS

a. DATE OF FORM COMPLETION: Enter the date the form is completed.
b. NEW OR REVIDED: Check "New" for initial form or "Revised" when updating the form.
c. MEDI-CAL ENROLLMENT: Check "Yes" if the NPI number and facility/building address on this form match the Medi-Cal Provider Master File (PMF). Check "No" if the NPI number and facility/building address do not match the Medi-Cal Provider Master File (PMF).
d. NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER: Enter the 10 digit NPI number for the facility/building address.
   - HIPAA provisions require all healthcare providers to have a National Provider Identifier (NPI).
e. PROVIDER TYPE: Use the pull down menu to identify the provider type.
   - HHAs (014) – Home Health Agencies apply for licensure and complete the Medi-Cal Provider Agreement through the California Department of Public Health. Health Care Facilities and Providers DPH Licensing.
   - Home and Community Based Center (HCBH) Benefit Provider (068)
   - Professional Corporation (069)
   - Private Non-Profit Proprietary Agency (095)
     - To Enroll in Medi-Cal, Home and Community Based Center Benefit Center Benefit Providers, Professional Corporations, and Private Non-Profit Proprietary Agencies, work with DHCS, Integrated Services Care Division (ISCD), Provider Enrollment Unit (PEU), available via email at WaiveProEnroll@dhcs.ca.gov.

LEGAL IDENTIFICATION SECTION INSTRUCTIONS

a. LEGAL ENTITY NAME: Enter the legal entity name. below are specified instructions:
   - **Corporation only:** For a corporation or Limited Liability Company (LLC) of any type this box must match exactly the name of the corporation (or LLC) as filed with the Secretary of State (SOS) and on the entity's articles of incorporation. To verify the exact wording of your legal name, please check the information at the SOS Website.
   - **Partnership only:** For a partnership that has filed a certification of limited partnership with the SOS, this box must match exactly the name filed. For a partnership of any type that has not filed a certification of limited partnership with the SOS, this box must contain the surnames of the partners.
   - **Sole Proprietor only:** For a sole proprietorship, this box must be the full legal name of the sole proprietor. A fictitious business name statement or business license is required if the sole proprietor name is different from the name of the facility.
b. PROGRAM/FACILITY NAME: Enter the name of the Program/Facility. Do not include the legal entity name in this box unless the Program/Facility name is the same as the legal entity name. Do not include the words or abbreviation for "Doing Business As" unless you actually intend to use those words or the abbreviation in the program's name.
c. FEDERAL TAX IDENTIFICATION NUMBER: Enter Federal Tax Identification Number. An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. (See IRS Letter SS-4, IRS Form 941, Form 8109-C, or Letter 147-C)

d. TYPE OF ORGANIZATION: Identify the type of organization, i.e., for Profit, Nonprofit, Government, or Other. If “Other” is identified, provide a detailed description, including the government entity that granted the status.
e. AUTHORIZED SIGNATORY NAME AND TITLE: Enter the name and title of tan individual who is authorized to execute the contract on behalf of the corporation, partnership, or other legal entity.
f. FACILITY/BUILDING ADDRESS: Enter the same address identified on the organization’s NPI documentation.
g. ADMINISTRATIVE/CORPORATE ADDRESS: Enter the physical address of the legal entity’s main office. This address may match the facility/building address if the entity does not have a separate Administrative/Corporate address.
h. MAILING ADDRESS: Enter the facility’s mailing address. A P.O. Box may be used as a mailing address. Note: the department will use this address to send all official mail.

Additional Information

Main Phone Number: _____ Toll Free Number: _____ Fax Number: _____

Counties/Los Angeles County Regions Served by CCT LO

Website Address: _____

Executive Director/Chief Executive Officer

Name: _____ Title: _____

E-mail: _____ Work Phone: _____

Designated CCT LO Program Contact

Name: _____ Title: _____

E-mail: _____ Work Phone: _____

Back-up CCT LO Program Contact

Name: _____ Title: _____

E-mail: _____ Work Phone: _____

CCT LO Invoicing Contact

Name: _____ Title: _____

E-mail: _____ Work Phone: _____

Registered Nurse

Name: _____ Title: _____

E-mail: _____ Work Phone: _____

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INSTRUCTIONS

a. ADDITIONAL INFORMATION: Enter main phone number, toll free telephone number, and fax number.
b. COUNTIES/LOS ANGELES COUNTY REGIONS SERVED BY CCT LO: Specify the county and/or Los Angeles County region the LO will serve, and establish working relationships with local inpatient nursing facilities.
   - **Los Angeles County Regions include:**
     - Angeles Forest
     - Antelope Valley
     - Central Los Angeles (L.A.)
     - Eastside
     - Harbor
     - Northeast L.A.
     - Northwest County
     - Pomona Valley
     - San Fernando Valley
     - San Gabriel Valley
     - Santa Monica Mountains
     - South Bay
     - South L.A.
     - Southeast
     - Verdugos
     - Westside
c. WEBSITE ADDRESS: Enter the website address.
d. EXECUTIVE DIRECTOR/CHIEF EXECUTIVE OFFICER: Enter the name of the individual who is designated to make administrative decisions.
e. DESIGNATED CCT LO PROGRAM CONTACT: Enter the name of the individual who is designated to respond to DHCS questions regarding the day-to-day program operations.
f. CCT LO INVOICING CONTACT: Enter the name of the individual who is able to respond to DHCS questions on claims for reimbursement.
g. REGISTERED NURSE: Enter the name of the licensed Registered Nurse with whom the CCT LO has hired, contracted, or established a legal working relationship. For additional guidance, see CCT Policy Letter 15-001 RN Transition.

For questions or technical assistance with the CCT LO Information Form, please contact the CCT Team at California.CommunityTransitions@dhcs.ca.gov.