The Homecoming Project Partners:

Catholic Charities Diocese of Stockton
1106 N. E St. Stockton, CA 95204
Tel: (209) 461-5112

1800 N. California St.
Community Health Interfaith Caregivers
St. Joseph’s Medical Center
1106 N. El Dorado St. Stockton, CA 95204
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The Homecoming Project
Transitional Care Program
Hospital-to-Home transitional care services to ensure a safe and successful transition to home.
What is the Homecoming Project?
The Homecoming Project is a hospital-to-home service that bridges the gap between a hospital discharge and a strong recovery. We provide care management and services after a patient returns home to help stabilize and achieve optimal recovery.

How can the Homecoming Project benefit you?
The program will:
- Coordinate transportation to medical appointments.
- Establish follow-up care with your primary care doctor.
- Arrange for housekeeping, personal care or meal planning.
- Assess for medical equipment, grab bars, life alert, etc.
- Coordinate medication delivery.

How does the program work?
The St. Joseph’s Medical Center Homecoming Coordinator will visit the patient in the hospital and then the Transitional Care Specialist will visit the patient at home after discharge. The Transitional Care Specialist will help the patient secure arrangements to his/her medical appointments and ensure medication delivery and link the patient with resources and support services that bridge the gap between a hospital discharge and a strong recovery. We provide care management and that helps the patient return home safely and achieve optimal recovery. The Homecoming Project is a hospital-to-home service for St. Joseph’s Medical Center patients who are ready for discharge and will be returning to their home.

Who is eligible?
St. Joseph’s Medical Center patients who are ready for discharge and will be returning to their home are eligible for the program. The free services are offered regardless of income. Homecoming clients may feel isolated, need additional support systems and resources and have other needs that place them at risk of readmission. The services are offered after discharge and will be returning to their home.

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