Discharge Protocols for
Community Services Boards and State Mental Health Facilities

The attached protocols are designed to provide consistent direction and coordination of those activities required of state facilities and Community Services Boards (CSBs) in the development and implementation of discharge planning. The activities delineated in these protocols are based on or referenced in the *Code of Virginia* or the Continuity of Care Procedures in the Community Services Performance Contract. In these protocols, the term CSB includes local government departments with policy-advisory CSBs, established pursuant to §37.1-195 of the *Code of Virginia,* and behavioral health authorities, established pursuant to §37.1-242 et seq. of the *Code of Virginia*.

DEFINITIONS

The following words and terms, when used in these protocols, shall have the following meanings, unless the context clearly indicates otherwise.

Acute Admissions or Acute Care Services means services that provide intensive short term psychiatric treatment in state mental health facilities for a period of less than 30 days after admission.

Case Management CSB means a citizen board established pursuant to 37.1-195 of the *Code of Virginia* that serves the area in which an adult resides or in which a minor's parent, guardian or legally authorized representative resides. The case management CSB is responsible for case management, liaison with the facility when an individual is admitted to a state facility, and discharge planning. If an individual, the parents of a minor receiving service, or legally authorized representative chooses to reside in a different locality after discharge from the facility, the community services board serving that locality becomes the case management CSB and works with the original case management CSB, the individual receiving services, and the state facility to effect a smooth transition and discharge. Reference in these protocols to CSB means Case Management CSB, unless the context clearly indicates otherwise.

Comprehensive Treatment Planning Meeting means the meeting, which follows the initial treatment meeting and occurs within seven (7) days of admission to a state mental health facility. At this meeting, the individual's Comprehensive Treatment Plan (CTP) is developed by the Treatment Team in consultation with the individual, the legally authorized representative, the CSB and with the individual's consent, family members and private providers. The purpose of the meeting is to guide, direct and support all treatment aspects for the individuals receiving services.

Discharge plan or **pre-discharge plan** hereafter referred to as the discharge plan means an individualized plan for post-hospital services that is developed by the case management CSB in accordance with § 37.1-197.1 and § 16.1-346.1 of the *Code of Virginia* in consultation with the state mental health facility Treatment Team. This plan describes the community services and supports needed by the individual being served following an episode of hospitalization and identifies the providers of such services and supports. The discharge plan is required by § 37.1-197.1, § 16.1-346.1 and § 37.1-98 of the *Code of Virginia*. A completed or finalized discharge plan means the *Discharge Plan Form (DMH 1190C or DMH 1190)* on which all of the services to be received upon discharge are shown, the providers that have agreed to provide those services are identified, the frequency of those services is noted, and a specific date of discharge is entered.

Dual Diagnosis means an individual who has been clinically assessed as having both a serious mental illness and:

1. a diagnosis of mental retardation as defined in § 37.1-1 of the *Code of Virginia*, (the accepted acronym for this population is MI/MR) **OR,**
2. a co-occurring/co-existing substance abuse or addiction disorder, per criteria in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM), designated by the American Psychiatric Association.

Extended Rehabilitative Services means services provided for a period of 30 days or more after admission that offer intermediate or long term treatment in a state facility for individuals with severe psychiatric impairments, emotional disturbances, or multiple service needs (e.g. persons who are mentally ill and deaf).

Involuntary admission means an admission of an adult or minor that is ordered by a court through a civil procedure according to § 37.1-67.3 or § 16.1-346.1 of the *Code of Virginia*.

Legally Authorized Representative means a person permitted by law or regulations to give informed consent for disclosure of information and give informed consent to treatment on behalf of an individual who lacks the mental capacity to make such decisions.

Minor means an individual who is under the age of eighteen years.

Pre-admission screening means a face-to-face clinical assessment of an individual performed by a CSB to determine the individual's need for inpatient care and to identify the most appropriate and least restrictive alternative to meet the individual's need.

Primary substance abuser means an individual who is clinically assessed as having one or more substance abuse or dependence disorders per the current DSM; and the individual does not have an Axis I Mental Health disorder per the current DSM.

State Mental Health Facility or State Facility for purposes of these protocols, means a state mental health facility under the supervision and management of the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

Treatment Team means the group of individuals that is responsible for the care and treatment of the individual during the period of hospitalization. Team members shall include, at a minimum, the individual receiving services, a psychiatrist, a psychologist, a social worker, and a registered nurse. While not actual members of the facility Treatment Team, CSB staff shall actively participate, collaborate, and consult with the Treatment Team during the individual's period of hospitalization and is responsible for the preparation and, where appropriate, the implementation of the discharge plan.

Treatment Plans mean written plans that identify the individual's treatment, training, and service needs and stipulate the goals, objectives and interventions designed to address those needs. There are two sequential levels of Treatment Plans:

1. The "Initial Treatment Plan," which directs the course of care during the first hours and days after admission; and
2. The "Comprehensive Treatment Plan (CTP)," developed by the Treatment Team with CSB consultation, which guides, directs and supports all treatment of individuals receiving services.

Treatment Plan Review (TPR) means treatment planning meetings or conferences held subsequent to the Comprehensive Treatment Plan meeting.

I. Admission to State Facilities

	Facility Responsibilities	CSB Responsibilities
1.1		Section 37.1-197.1 of the *Code of Virginia* states that Community Services Boards (CSBs) are the single points of entry for publicly funded mental health, mental retardation, and substance abuse services**.** Section 37.1-67.1 of the *Code of Virginia* also stipulates that it is the responsibility of CSBs to perform a face-to-face pre-admission screening that confirms the appropriateness of admission to a state facility. **NOTE**: The *Code of Virginia* Sections 19.2-169.6, 19.2-176, 19.2-177.1 for Adults and Section 16.1-275 under the Juvenile provisions do not require NGRIs, Mandatory Parolees, or transfers from jail for treatment, evaluation or restoration to be prescreened by a CSB unless the individuals is being admitted for emergency treatment under a TDO pursuant to the above mentioned sections.
1.2	Upon admission, if the person is not able to make the necessary decisions (lacks the capacity to make an informed decision) regarding treatment and discharge planning and there are no family members available, state facility staff shall arrange for substitute consent as appropriate.	

	Facility Responsibilities	CSB Responsibilities
1.3	The state facility Treatment Team and Utilization Review Department, and, as appropriate the Forensic Coordinator, shall assess each individual upon admission and periodically thereafter to determine whether the state facility is an appropriate treatment site. These assessments shall be made available to the Case Management CSB for purposes of treatment and discharge planning. ***RECOMMENDED PRACTICES:*** 1. For individuals with the dual diagnosis of MR/MI, both the admitting Mental Health Facility and the region's Mental Retardation Training Center should confer to determine which institution can best serve the individual's needs. 2. If the individual with a dual diagnosis of MR/MI is sent to a State Mental Health Facility under a Temporary Detention Order (TDO), consultation prior to or participation at the commitment hearing is expected of: a. The Admitting Facility b. The Catchment Area's Training Center c. The Case Management CSB's Mental Health Services Staff d. The Case Management CSB's Mental Retardation Services Staff.	As active participants in the discharge process and consultants to the treatment process, CSB staff shall participate in assessments to determine whether the state facility is an appropriate treatment site. ***RECOMMENDED PRACTICE:*** It should be the CSB's responsibility to notify its service area's state MH and MR facility of any known individual with the dual diagnosis of MR/MI who is receiving local inpatient services either through Temporary Detention Order, Civil Commitment or Voluntary Admission and who may require additional treatment in a state facility.
1.4	Facility staff shall contact the Case Management CSB by telephone within 24 hours of admission, or for weekends and holidays on the next working day, to notify the CSB of the new admission. In addition to contact by the Social Worker, Facility staff shall also fax a copy of the admissions face sheet, including the name and phone number of the Social Worker assigned and the name of the admitting ward, to the CSB within one (1) working day of admission. **NOTES**: 1. For all forensic admissions, Facility staff shall provide the CSB with a patient information sheet within one (1) working day of admission.	Upon notification of admission, CSB staff shall begin the discharge planning process. If the CSB disputes case management responsibility for the individual, the CSB shall notify the facility Social Worker immediately upon notification of admission. **NOTES**: 1. CSB staff is not responsible for completing the discharge planning forms for individuals admitted to a State Mental Health Facility and who are discharged prior to the CTP. However, CSB responsibilities post discharge will be reflected in the Discharge Instructions - Form 226. (Please see Attachment 3)

	Facility Responsibilities	CSB Responsibilities
1.4	2. Treatment Teams are not responsible for completing the Needs Upon Discharge Form for any individual admitted to a State Mental Health Facility and who is discharged prior to the CTP. However, the Treatment Team is responsible for completing the Discharge Instructions (Form 226). ***RECOMMENDED PRACTICE:*** When reporting admissions to the CSBs, facility staff should specify those individuals admitted to a state facility with a primary diagnosis of substance abuse.	2. For all forensic admissions, the CSB shall participate in the treatment and discharge process in accordance with these protocols. 3. For every admission to a State Mental Health Facility for individuals from the CSB's service area who are currently not served by that CSB, the CSB shall develop an open case and assign Case management responsibilities to the appropriate staff**.** (Please see SFY 2002 Community Services Performance Contract Section 5.3.5) ***RECOMMENDED PRACTICE:*** For each admission, the CSB should make every effort to establish a personal contact (face-to-face, telephone, etc.) at least weekly for acute admissions and at least monthly for those individuals receiving extended rehabilitative services.
1.5	The Treatment Team shall, to the greatest extent possible, accommodate the CSB when scheduling CTP and Treatment Plan Review (TPR) meetings. Facility staff shall inform the CSB of the date and time of the Comprehensive Treatment Plan (CTP) meeting at least 48 hours prior to the scheduled meeting. **NOTE**: The CTP meeting shall be held within seven (7) calendar days of the date of admission. ***RECOMMEDED PRACTICES:*** 1. Facilities should develop centralized scheduling for all CTP and TPR meetings. This process should be automated to allow for the posting of an e-mail calendar that would also provide advance notice for all treatment planning meetings. This e-mail calendar should be accessible to all the CSBs served by the facility. 2. Special consideration shall be made for scheduling and discharging individuals admitted with a primary substance abuse diagnosis, with attention focused on diversion efforts and other community alternatives.	CSB staff shall make arrangements to attend or otherwise participate in the CTP and TPR meetings. If the CSB staff is unable to physically attend the CTP or TPR meeting, it is CSB's responsibility to notify the Facility Social Worker and request arrangements for telephone or video conferencing accommodations. In the event that the above mentioned are not possible, it is the responsibility of the CSB staff to contact the Treatment Team or Facility Social Worker to discuss case specifics prior to receipt of the *Needs Upon Discharge Form.* **NOTES:** 1. While it may not be possible for the CSB to attend every treatment planning meeting, it is understood that attendance at treatment planning meetings is the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans. 2. A basic principle is that all individuals who are clinically ready for discharge should be seen face-to-face by CSB staff before they are discharged from the state facility. 3. For those individuals receiving extended rehabilitation services (those in a state

	Facility Responsibilities	CSB Responsibilities
1.5		facility for 30 days or more), CSBs shall ensure attendance in person at no less than one CTP or TPR meeting within 45 calendar days prior to the discharge of the individual. 4. For those individuals receiving acute care services (those in a state facility for less than 30 days), CSBs shall ensure attendance at no less than one CTP or TPR meeting prior to the discharge of the individual unless: a. The individual is discharged before the CTP; or b. Based on the clinical judgment of CSB staff, a face-to-face contact is not necessary (e.g. the CSB has seen the individual within the past 60 days as a consumer of its services), the CSB has documented this determination in the patient's medical record, and the CSB has had communication (i.e., teleconference or video conference) with the individual and the Treatment Team that explains and discusses this determination.
1.6	The state facility in collaboration with CSB staff shall arrange for telephone and video conferencing accommodations for CSB staff, legally authorized representatives, and family members who are invited to attend meetings but are unable to attend in person.	

II. Needs Assessments & Discharge Planning

	Facility Responsibilities	CSB Responsibilities
2.1	The Treatment Team, with CSB consultation, shall ascertain, document and address the preferences of the individual or his legally authorized representative in the needs assessment and discharge planning process that will promote elements of recovery, self-determination and community integration.	
2.2	The Facility Social Worker shall complete a Psychosocial Assessment prior to the CTP for each individual receiving services. This assessment shall serve as one basis for determining the individual's needs upon discharge from the state facility. The Treatment Team shall document the individual's preferences in assessing the needs upon discharge from the state facility. Although the entire Treatment Team and CSB staff shall participate in evaluating the individual's needs, the Facility Social Worker (or designee) is responsible for documenting these needs on the *Needs Upon Discharge Form (DMH 1190F)* section of the Comprehensive Treatment Plan. (Please see Attachment 1) **NOTES:** 1. For individuals with an MR/MI diagnosis who may be eligible for services under the Medicaid Waiver, the following shall be established: a. That Facility staff has conducted a current psychological assessment. b. That Medicaid eligibility has been determined and confirmed.	CSB staff shall initiate discharge planning upon the individual's admission to a state facility. Discharge planning begins on the Initial Pre-Screening form and continues on the *Discharge Plan Form (DMH 1190C)* section of the CTP. (Please see Attachment 1). In completing the *Discharge Plan*, the CSB shall consult with members of the Treatment Team, the individual receiving services, his legally authorized representative, and, with his consent, family members or other parties in determining the preferences of the individual upon discharge. The Discharge Plan shall be developed in accordance with the *Code of Virginia* and the Community Services Performance Contract and shall: • include the anticipated date of discharge from the state facility; • identify the services needed for successful community placement; and • specify the public or private providers that have agreed to provide these services. **NOTES**: 1. For individuals with an MR/MI diagnosis, CSB Division Directors for Mental Health and Mental Retardation (or designees) shall conduct both case review and an assessment of the CTP to ensure intra-agency coordination. 2. For individuals with an MR/MI diagnosis who may be eligible for services under the Medicaid Waiver, the following shall be established: a. That a Level of Functioning (LOF) assessment has been completed by the CSB.

	Facility Responsibilities	CSB Responsibilities
2.2		b. That the Inventory for Client and Agency Planning (ICAP) has been completed. ***RECOMMENDED PRACTICE*:** For those individuals who are deaf, hard of hearing, late deafened, or deaf-blind, the CSB should coordinate the discharge planning effort with the Regional Deaf Coordinator.
2.3	The *Needs Upon Discharge* form shall be filled out as completely as possible by the Facility Social Worker (or designee) at the CTP meeting. If the CSB is not present at the CTP meeting, facility staff shall fax a copy of the *Needs Upon Discharge* form to the CSB within one (1) working day of the CTP meeting.	At the initial CTP meeting, CSB staff shall fill out as completely as possible the *Discharge Plan* section of the CTP and sign the CTP. If CSB staff is unable to attend the meeting, they shall send a copy of the *Discharge Plan* to the Facility Social Worker within three (3) working days of the initial CTP meeting (or receipt of the *Needs Upon Discharge Form*). The *Discharge Plan* must address each need identified on the *Needs Upon Discharge* section of the form.
2.4		The *Discharge Plan* cannot be filled out in the absence of the *Needs Upon Discharge* form. If the *Needs Upon Discharge* form is not available at the initial CTP meeting or within one (1) working day: • CSB staff shall notify the Treatment Team leader and Facility Social Worker. • If the *Needs Upon Discharge* form is not made available upon notification of the problem, the CSB staff shall notify the CSB Mental Health Director (or designee) who shall notify the Facility Social Work Director of the problem. • If the facility does not address the delinquencies, the CSB Executive Director shall contact the Facility Director in writing within two (2) working days of notification by the CSB Mental Health Director (or designee). • If completion of the *Needs Upon Discharge* form remains problematic, the CSB Executive Director shall notify the Assistant Commissioner for Facility Management in writing of the problem and include supporting documentation.

	Facility Responsibilities	CSB Responsibilities
2.5	The *Needs Upon Discharge* form shall be initiated at the first CTP meeting and updated at subsequent TPR meetings. As an individual's needs change, the Facility Social Worker shall document changes on the *Needs Upon Discharge* section of the CTP and in the Facility Social Worker's progress notes.	The *Discharge Plan* form shall be initiated at the first CTP meeting and updated at subsequent meetings. If the individual's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the Discharge Plan to address changes to the Needs Assessment. ***RECOMMENDED PRACTICE:*** Where applicable, CSB Mental Health, Mental Retardation and Substance Abuse staff should work jointly in the development and execution of the discharge plan.
2.6	In the event that a CSB fails to initiate the *Discharge Plan* form within three (3) working days of the initial CTP or receipt of the *Needs Upon Discharge Form* and other information from the state facility: • The Treatment Team Leader or designee shall notify the Director of Social Work and the Facility Director in writing of the problems and issues associated with the development or completion of the *Discharge Plan.* • If the CSB fails to initiate the *Discharge Plan* form upon notification of the problem, the Facility Social Work Director shall notify the CSB Mental Health Director (or designee) of the problem and document the contact in the individual's medical record. • If the CSB does not address the delinquencies, the Facility Director shall contact the CSB Executive Director in writing within two (2) working days of notification by the Treatment Team requesting a meeting with the Executive Director and Mental Health Director (or designee) in an effort to resolve the problems and issues associated with the development or completion of the *Discharge Plan.* • If the development or completion of the Discharge Plan by the CSB remain problematic, the Facility Director shall notify the Assistant Commissioners of	

	Facility Responsibilities	CSB Responsibilities
2.6	Facility Management and of Administrative and Regulatory Compliance in writing of the problem and include supporting documentation.	
2.7		As part of the individual's medical record, the CSB shall provide weekly discharge planning notes for individuals being treated on state facility admission wards. Discharge planning notes document the CSB's progress in discharging the individual. For those individuals being treated on other wards, discharge planning notes are required every 30 days. **NOTES:** 1. For those individuals found Not Guilty by Reason of Insanity (NGRI) who are being treated on civil wards, a discharge planning note is required weekly on admission wards and every 30 days on other wards. As the individual receives unescorted overnight community visits then discharge planning notes will be required every 14 days. 2. A CSB presence at the state mental health facility is not required for the completion of discharge planning notes. Discharge planning notes may be forwarded to the facility by secure e-mail, facsimile or mail.

III. Individualized Treatment Planning

	Facility Responsibilities	CSB Responsibilities
3.1	The Treatment Team, in consultation with CSB staff, shall develop an individualized treatment plan that is designed to lead to discharge. The Treatment Team shall, with the individual's and the CSB's input and recommendations, develop goals that will indicate the end of the treatment phase at the facility.	
3.2	Individuals receiving services**,** legally authorized representatives and, with the individual's consent, family members and private providers who will be involved in providing services shall be included in the treatment planning process and shall be asked to sign the treatment plan if present at treatment team meetings.	
3.3	The behaviors and skills that the individual will need to be successful in the designated discharge site shall drive treatment in a manner that will promote a successful discharge and avoid unnecessary readmission.	
3.4	With the individual's consent, facility staff, in collaboration with CSB staff, shall notify family members by telephone of dates and times of the Treatment Team meetings whenever possible.	
3.5	The Treatment Team, with CSB consultation, shall ascertain, document, and address the preferences of the individual or his legally authorized representative as to the placement upon discharge. **NOTE**: This may not be applicable for certain forensic admissions due to their legal status**.**	

IV. READINESS FOR DISCHARGE

	Facility Responsibilities	CSB Responsibilities
4.1	When the individual receiving services achieves the treatment goals identified in his CTP, the Treatment Team, with CSB consultation, may determine that the individual is clinically ready for discharge if the individual is medically stable and state facility level of care is no longer required or, for voluntary admissions, when consent has been withdrawn; and for **children and adolescents** any of the following: • The minor is unlikely to benefit from further acute inpatient psychiatric treatment; or • The minor has stabilized to the extent that inpatient psychiatric treatment in a state facility is no longer the least restrictive treatment intervention; or • If the minor is a voluntary admission, the legal guardian, or the minor if he is age 14 or older, has withdrawn consent for admission.	
4.2	Decisions regarding discharge readiness shall be made at CTP or TPR meetings. The CSB staff and the individual or his legally authorized representative shall be a part of the decision making process in determining whether or not the individual is ready for discharge The Treatment Team shall notify the Facility Director (or designee) when an individual is determined ready for discharge. If the CSB staff has not participated in the CTP or TPR meeting when an individual was determined to be ready for discharge, the Facility Social Worker is responsible for communicating decisions regarding discharge readiness to the CSB staff. The Facility Social Worker shall, by telephone contact the CSB within one (1) working day of the meeting and provide notification of readiness for discharge and document the call in the patient's medical record. This contact is to be followed by a written notification to the CSB. **NOTE:** The Facility Social Workers shall notify the Social Work Director or Forensic Coordinator and the CSB of any individual receiving forensic services who has been identified by the Treatment Team as clinically and legally ready for discharge to a correctional center or facility. ***RECOMMENDED PRACTICE*:** For those individuals being served on extended rehabilitation wards at state facilities, and for whom recovery is delayed due to the extent of their illness, the anticipated date of discharge should be assessed at least every 90 days.	

	Facility Responsibilities	CSB Responsibilities
4.3		If the CSB agrees that the individual is ready for discharge, it shall take immediate steps to finalize the *Discharge Plan* within no more than ten (10) working days. The individual shall be discharged from the facility as soon as possible but in no more than 30 calendar days of the notification except as provided for in Section 4.6, when the CSB experiences extraordinary barriers making it impossible to complete the discharge within 30 calendar days of notification. **NOTES:** 1. A basic principle is that all individuals who are clinically ready for discharge should be seen face-to-face by CSB staff before they are discharged from the state facility. 1. For those individuals receiving extended rehabilitation services (those in a state facility for 30 days or more), CSBs shall ensure attendance in person at no less than one CTP or TPR meeting within 45 calendar days prior to the discharge of the individual. 3. For those individuals receiving acute care services (those in a state facility for less than 30 days), CSBs shall ensure attendance at no less than one CTP or TPR meeting prior to the discharge of the individual unless: a. The individual is discharged before the CTP; or b. Based on the clinical judgment of CSB staff, a face-to-face contact is not necessary (e.g. the CSB has seen the individual within the past 60 days as a consumer of its services), the CSB has documented this determination in the patient's medical record, and the CSB has had communication (i.e., teleconference or video conference) with the individual and the Treatment Team that explains and discusses this determination.

	Facility Responsibilities	CSB Responsibilities
4.4	State facility staff shall collaborate with CSB staff as needed in finalizing the *Discharge Plan.* **NOTE**: It is the sole responsibility of the CSB to make individual referrals to private providers, including Assisted Living Facilities (ALFs). The Case Management CSB may request that facility staff assist the referral process as needed. ***RECOMMENDED PRACTICE:*** For Acute Admissions, CSBs and Treatment Teams will accelerate the discharge process to shorten the time frames recommended and ensure continuity for existing community supports.	
4.5		After discharge, if the individual is not able to make the necessary decisions regarding treatment in the community, CSB staff shall arrange for substitute consent as appropriate. ***RECOMMENDED PRACTICE*:** Whenever possible, substitute consent needs to be in place by the date of discharge.
4.6		In the event the CSB experiences extraordinary barriers, including insufficiency of state funding and the lack of community infrastructure (including willing providers), making it impossible to complete the discharge within 30 calendar days of notification, the CSB must submit written notification to the Facility Director and the Commissioner of DMHMRSAS documenting why the discharge cannot occur within 30 days of notification. The documentation must describe the barriers to discharge and the specific steps being taken by the CSB to address them. This documentation shall be submitted no later than 30 calendar days from the notification of readiness for discharge. This shall be documented in the individual's Discharge Plan and the CSB discharge planning notes that are part of the individual's medical record.
4.7	Facility and CSB staff shall review on a monthly basis those cases that have been submitted to the Facility Director and the Commissioner of DMHMRSAS as impossible to discharge within 30 days and document the CSB's progress in addressing barriers to ensure that discharges are occurring at reasonable pace.	

	Facility Responsibilities	CSB Responsibilities
4.8	If the CSB agrees that the individual is ready for discharge but has neither completed nor implemented the discharge plan: • The Treatment Team Leader/Designee shall notify the Director of Social Work and the Facility Director in writing of the problems and issues associated with the CSB's completion of the *Discharge Plan.* • The Facility Director shall contact the CSB Executive Director in writing within two (2) working days of notification by the Treatment Team, and • If discharge efforts by the CSB remain problematic, the Facility Director shall notify the Assistant Commissioner for Facility Management and the Assistant Commissioner for Administrative and Regulatory Compliance in writing of the problem and include supporting documentation.	
4.9		If the CSB disagrees that the individual is clinically ready for discharge, the Executive Director shall notify the Facility Director and Treatment Team in writing within 10 working days of the notification of readiness for discharge. Also, the CSB staff must document the disagreement in the CSB discharge planning notes section of the patient's medical record within 30 calendar days of said notification.
4.10	When disagreements regarding readiness for discharge occur**,** the CSB and the state facility are expected to make a reasonable effort to resolve the disagreement before sending a written request for resolution to DMHMRSAS. This effort is to include at least one face-to-face meeting with state facility and CSB staff at a level higher than the Treatment Team with written documentation of the meeting's contents included in the individual's medical record.	
4.11	In the event that a resolution is not forthcoming, the party disagreeing with the individual's clinical readiness for discharge is responsible for initiating a request in writing to DMHMRSAS under the conditions specified in Attachment 5.3.4 of the Community Services Performance Contract.	

V. COMPLETING THE DISCHARGE PROCESS

	Facility Responsibilities	CSB Responsibilities
5.1	Facility staff in collaboration with CSB staff shall initiate applications for Medicaid, Medicare, SSI/SSDI and other financial entitlements (e.g., indigent medications). Applications shall be initiated in a timely manner prior to actual discharge when possible. For individuals receiving extended rehabilitation services at the facility, the application process shall begin not less than 30 days prior to the anticipated date of discharge. Each team member is responsible for timely and comprehensive reports as required for the applications. To facilitate follow-up, the Facility Social Worker shall notify the CSB of the date and type of entitlement application that is submitted. This will also be reflected in the *Needs Upon Discharge* section of the individual's *Discharge Plan*.	
5.2	The Treatment Team shall prepare the *Discharge Information and Instructions-Form #226* (Attachment 3) and obtain the physician's review and signature prior to discharge. At the actual time of discharge, facility staff shall review the *Discharge Information and Instructions* sheet with the individual or his legally authorized representative and request his signature. **NOTE**: Individual review of the *Discharge Information and Instructions* may not be applicable for certain forensic admissions due to their legal status. ***RECOMMENDED PRACTICE:*** A psychiatrist shall evaluate the patient and document the evaluation in 24 hours or less before the time of discharge.	To reduce re-admissions to state mental health facilities, CSBs shall develop, as appropriate and on an individual basis, a crisis intervention plan that is part of the final *Discharge Plan*. (See Attachment 2 for template design) **NOTES**: 1. Crisis plans are not required for individuals who have been acquitted as Not Guilty by Reason of Insanity (NGRI). 2. Similar documentation is included in the court documents and approved by the Forensic Review Panel. 3. Crisis Plans are not required for Court Ordered Evaluations, Restoration to Competency cases, and Jail Transfers. 4. For individuals with the dual diagnosis of MR/MI, an individualized behavior management or a crisis plan must be part of the *Discharge Plan*. These plans must work in conjunction with any pre-existing MR/MI protocols developed between the facility and it's service area. ***RECOMMENDED PRACTICES*:** 1. CSB staff should ensure that all arrangements for Psychiatric services and medical follow-up appointments are in place prior to discharge. 2. CSB staff should ensure the coordination of any other intra-agency services, e.g., employment, outpatient services, residential, etc.

	Facility Responsibilities	CSB Responsibilities
5.3	The Facility Medical Director shall be responsible for ensuring that the *Discharge Summary* is provided to the case management CSB within fourteen (14) calendar days of the actual discharge date.	
5.4		The CSB case manager, primary therapist, or other designated staff shall schedule an appointment to see individuals who have been discharged from a state mental health facility within seven (7) calendar days of discharge or sooner if the individual's condition warrants.
5.5		Individuals discharged from a state mental health facility who have missed their first appointment with the CSB case manager, primary therapist, psychiatrist, or day support program shall be contacted no later than 24 hours after the missed appointment. Written documentation shall be provided of efforts to see the person face-to-face no later than seven (7) calendar days after the missed appointment.
5.6		Individuals discharged from a state mental health facility with continuing psychotropic medications needs shall, to the extent practicable, be scheduled to be seen by the CSB psychiatrist within seven (7) calendar days post discharge, or sooner if the individual's condition warrants. In no case shall this initial appointment be scheduled longer than 14 calendar days following discharge.

VI. TRANSFER OF CASE MANAGEMENT CSB RESPONSIBILITIES

	Facility Responsibilities	CSB Responsibilities
6.1	The Facility Social Worker shall indicate in the progress notes any intention expressed by the individual receiving services or his legally authorized representative to change or transfer Case Management CSB responsibilities and the reason(s) for doing so. Prior to any further discussion with the individual, his legally authorized representative, family, or other parties, Facility Staff shall contact both the Case Management CSB and the CSB affected by the individual's intention to transfer so that they may begin discussion. This shall be documented in the individual's medical record.	Transfers shall occur when the individual receiving services or his legally authorized representative decides to relocate to another CSB service area. ***RECOMMENDED PRACTICE*:** Coordination of the possible transfer should allow for discussion of resources availability and resource allocation between the two CSBs prior to advancement of the transfer**.**
6.2		Transfer of Case Management CSB responsibility shall be handled according to DMHMRSAS policies and procedures as discussed in Section 4.5 of the *Procedures for Continuity of Care Between Community Services Boards and State Psychiatric Facilities*.
6.3		Exceptions to the above, shall be granted only when the CSB and individual receiving services or his legally authorized representative agree to keep services at the Case Management CSB while living in a different service area.
6.4	Facility Staff shall provide written notification to the current and new case management CSB at least 48 hours before the final TPR meeting. The Treatment Team shall to the greatest extent possible accommodate both CSBs when scheduling the final TPR meeting.	Case Management services must be provided by the new CSB promptly upon notification of transfer. This shall be effective no later than one week prior to the date of discharge. At a minimum, the new Case Management CSB shall attend the final Treatment Plan Review (TPR) meeting prior to the actual discharge date. The CSB of origin shall stay involved with the case for no less than 30 calendar days post discharge. The arrangements for and logistics of this involvement are to be documented in the *Discharge Plan*. **NOTE**: The criteria delineated in this section shall also apply to individuals with the dual diagnoses of MH/SA and MR/MI regardless of vendor, Medicaid Waiver eligibility or placement site.

	Facility Responsibilities	CSB Responsibilities
6.4		***RECOMMENDED PRACTICE*:** The CSB of origin should, upon notice of transfer, provide the new CSB with a copy of all relevant documentation related to the treatment of the individual.
6.5		If the two CSBs cannot agree on the transfer of case management responsibility before the individual is discharged, they shall seek resolution from the Assistant Commissioner for Facility Management and the Assistant Commissioner for Administrative and Regulatory Compliance. The CSB of origin shall initiate this contact.

ATTACHMENT 1

State Mental Health Facility
Needs Upon Discharge/Discharge Plan

Form Instructions
Form DMH 942E 1190 (combined *Needs Upon Discharge/Discharge Plan*)
Form DMH 942E 1190C (individual *Discharge Plan*)
Form DMH 942E 1190F (individual *Needs Upon Discharge*)
Form DMH 942E 1191 (*Needs Upon Discharge/Discharge Plan Addendum)*

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Form Instructions for *Needs Upon Discharge*, *Discharge Plan*, and *Addendum* (DMH 942E 1190, DMH 942I 1190F, DMH 942E 1190C and DMH 942E 1191)

I. *Needs Upon Discharge* (DMH 942E 1190 or DMH 942I 1190F)

The Treatment Team Social Worker (or designee), with input from the other members of the Treatment Team and CSB staff, shall initiate the *Needs Upon Discharge* at the time of the first Comprehensive Treatment Plan (CTP) meeting. The initial *Needs Upon Discharge* shall reflect the individual's needs based on clinical assessments and information available as of the initial CTP meeting. Throughout the course of the hospital stay, as the individual's needs change or as more information becomes available, the Treatment Team Social Worker shall revise the *Needs Upon Discharge* at subsequent Treatment Plan Review (TPR) meetings.

At the initial CTP meeting, the Treatment Team Social Worker (or designee) shall fill out the *Needs Upon Discharge* as completely as possible so the CSB may begin discharge planning. If the CSB representative is not present at the Treatment Team meeting, the Treatment Team Social Worker (or designee) shall fax a copy of the *Needs Upon Discharge* to him within one (1) working day. After receipt of the *Needs Upon Discharge*, the CSB staff shall initiate the *Discharge Plan* based upon the needs identified as of the first CTP. CSB staff shall fax the *Discharge Plan* to the Treatment Team Social Worker within three (3) working days of the Comprehensive Treatment Plan meeting and mail the original. The Treatment Team Social Worker (or designee) shall put the faxed copy in the medical record, replacing it with the original when it is received.

If a CSB representative is not present at any TPR meeting, the Treatment Team Social Worker (or designee) shall fax a copy of the revised *Needs Upon Discharge* to him within one (1) working day. After receipt of the revised *Needs Upon Discharge*, the CSB staff shall revise the *Discharge Plan* as needed and return the revised plan to the facility within three (3) working days of the TPR meeting (as above).

The *Needs Upon Discharge* shall be maintained in the *Comprehensive Treatment Planning* section of the individual's medical record. The *Needs Upon Discharge* may be completed on computer file if desired.

Initiating the *Needs Upon Discharge*:

At the initial CTP meeting, the Treatment Team Social Worker (or designee), with input from the other members of the Treatment Team and CSB staff, shall initiate the *Needs Upon Discharge* as follows:

In the **PRE-DISCHARGE** section:

- Under ***Individual's Motivation for Discharge***, rate the individual's motivation for discharge based on the individual's statements and behaviors regarding discharge as of the initial CTP meeting. Ratings should be based on a 5-point scale as follows:
  - 1= *Not Motivated*: Individual consistently states he does not want to leave the hospital or otherwise indicates no desire to be discharged (e.g., refuses discharge planning or never mentions discharge).
  - 2= *Slightly Motivated:* Individual occasionally indicates a desire for discharge or is at least receptive to the idea of discharge.
  - 3= *Ambivalent*: Individual displays conflicting feelings/behaviors about discharge, e.g. individual states he would like to be discharged, yet refuses to participate in discharge planning.
  - 4= *Moderately Motivated*: Individual states he would like to be discharged but is not fully engaged in the discharge planning process.
  - 5= *Highly Motivated:* Individual consistently states he would like to be discharged and is actively engaged in discharge planning process.

Form Instructions for *Needs Upon Discharge, Discharge Plan,* and *Addendum* (DMH 942E 1190, DMH 942I 1190F, DMH 942E 1190C and DMH 942E 1191)

- Under ***Individual's Preferences upon Discharge***, document the individual's *current* preferences upon discharge, i.e. what does the individual state he would like to do upon discharge?
- Under ***Anticipated Date of Discharge***, record the anticipated date of discharge determined by the Treatment Team as of the initial CTP meeting. **Note**: If the individual is on a legal status in forensic services that does not allow (for security purposes) the disclosure of a discharge date, then indicate this in the Anticipated Discharge Date section of the form.

In the **MEDICAL** section:

- Document and describe the individual's specific medical needs (e.g., lab work, follow-up for hypertension) based on assessments and information available as of the initial CTP meeting. Be as specific as possible.
- If the individual is not anticipated to have any special medical needs, check "Routine Health Maintenance".
- If needs are unclear as of the initial CTP meeting, check "Assess Needs".

In the **MEDICATION** section:

- Document and describe the individual's specific medication needs based on assessments and information available as of the initial CTP meeting. Be as specific as possible.
- If the individual is not anticipated to be on medication or is able to obtain/administer medications independently, check "No Needs (Independent or N/A)".
- If needs are unclear as of the initial CTP meeting, check "Assess Needs".

In the **SUBSTANCE ABUSE** section:

- Document and describe the individual's specific substance abuse needs based on assessments and information available as of the initial CTP meeting. Be as specific as possible.
- If the individual is not anticipated to have any substance abuse needs, check "No Needs (Independent or N/A)".
- If needs are unclear as of the initial CTP meeting, check "Assess Needs".

In the **PSYCHIATRIC/THERAPEUTIC** section:

- Document and describe the individual's specific psychiatric/therapeutic needs based on assessments and information available as of the initial CTP meeting. Be as specific as possible.
- If the individual is not anticipated to have any psychiatric/therapeutic needs, check "No Needs (Independent or N/A)".
- If needs are unclear as of the initial CTP meeting, check "Assess Needs".

In the **DAILY LIVING** section:

- Under each sub-section (***Hygiene, Nutrition, Transportation, Shopping, Money Management, Leisure/Socialization, Employment, Education***), document and describe the individual's specific daily living needs based on assessments and information available as of the initial CTP meeting. Be as specific as possible.
- If the individual is not anticipated to have any needs in a particular sub-section, check "No Needs (Independent or N/A)".
- If needs are unclear as of the initial CTP meeting, check "Assess Needs".

Form Instructions for *Needs Upon Discharge, Discharge Plan,* and *Addendum* (DMH 942E 1190, DMH 942I 1190F, DMH 942E 1190C and DMH 942E 1191)

In the **LEGAL** section:

- Under ***Competent to make decisions?***, specify whether individual has the capacity to make decision for himself ("Yes" or "No"). If the individual is under 18 years old, circle "Minor".
- Under ***Has LAR in Facility?,*** specify whether the individual has a legally authorized representative (LAR) in the facility (circle "Yes" or "No"). If yes, specify the name of the LAR.
- Under ***Has LAR in Community?,*** specify whether the individual has a LAR in the community (circle "Yes" or "No").
  If *No*, specify whether LAR in Community is needed (circle "Yes" or "No"). If LAR is needed in community circle the type of LAR needed (e.g., Legal Guardian).
  If *Yes*, provide the name of the individual serving as LAR in the community and specify the type of LAR (e.g., Power of Attorney)
- Under ***Other Legal Needs,*** document and describe any other legal needs (e.g. attorney, coordination with probation officer).

In the **FINANCIAL** section:

- Under ***SSI, SSDI, Medicaid, Medicare***, specify the amount (if applicable), type (e.g., QMB only) and status of each benefit (e.g., currently receives, needs re-application, pending, approved, etc.). If the individual is not eligible to receive any of these, indicate "Not Eligible" under status.
- Document any other financial entitlement needed.

In the **HOUSING** section:

- Document and describe the individual's specific housing needs based on assessments and information available as of the initial CTP meeting. Be as specific as possible.
- If the individual is not anticipated to have any housing needs (i.e., will return to prior housing), check "No Needs/Return to prior housing" and document location in space provided.
- If needs are unclear as of the initial CTP meeting, check "Assess Needs".

In the **SUPERVISION** Section:

- Document and describe the individual's specific supervision needs based on assessments and information available as of the initial CTP meeting. Be as specific as possible. Provide the reason why supervision is necessary and the frequency of the need, e.g. Supervision 1 hour per day, 7 days a week in AM and PM to administer medications and prompt individual to attend to activities of daily living (ADLs).
- If the individual needs supervision 24 hours per day, 7 days per week, specify whether overnight staff must be "awake" at all times or just accessible ("On-Site"). In addition, specify whether individual must be supervised directly at all times (circle "Yes" or "No")
- If the individual is not anticipated to have any supervision needs, check "No Needs".
- If needs are unclear as of the initial CTP meeting, check "Assess Needs".

In the **TRANSITION** section:

- Under ***Need for transition to community?,*** specify whether individual has the need for a transition plan (i.e. Does the individual have special needs regarding making the transition from hospital to community? Should the individual have a gradual transition to the community or would a gradual transition impede discharge?).

Form Instructions for *Needs Upon Discharge*, *Discharge Plan*, and *Addendum* (DMH 942E 1190, DMH 942I 1190F, DMH 942E 1190C and DMH 942E 1191)

- If yes, document and describe the individual's specific transitional needs. Be as specific as possible and provide the reason for the need, e.g. Individual has difficulty trusting others and, therefore, may have difficulty working with new staff in the community unless given the opportunity to meet new staff prior to discharge.
- If needs are unclear as of the initial CTP meeting, circle "Needs Assessment".

In the **CRISIS** section:

- Under ***Need for specialized crisis plan?,*** specify whether individual has the need for a specialized crisis plan (circle "Yes" or "No"). If yes, see Crisis Plan Template for suggestions on developing a crisis plan. If there is no need for a specialized crisis plan, please note that all individuals must at least have a "routine" crisis plan.
- Document and describe any issues for the CSB to address in a crisis plan (e.g., medication non-compliance, hospital dependency).

In the **OTHER** section:

- Document and describe any religious, cultural, and/or other needs anticipated upon discharge.
- If the individual is not anticipated to have any other needs, check "No Needs"
- If needs are unclear as of the initial CTP meeting, check "Assess Needs".

In the **SIGNATURES** section:

- Sign and date the form in the designated spaces on page 6 of the combined *Needs Upon Discharge*/*Discharge Plan* form or page 3 of the *Needs Upon Discharge* form.
- Review the *Needs Upon Discharge* with the individual receiving services and/or legally authorized representative (LAR) and obtain their signatures in the designated spaces on page 6 (left-hand column) of the combined *Needs Upon Discharge*/*Discharge Plan* form (DMH 942E 1190) or page 3 of the *Needs Upon Discharge* form.

In the **ADDRESSOGRAPH** section:

- Stamp each page in the designated space at the bottom right of the page.

Updates & Revisions to *Needs Upon Discharge*:

At subsequent TPR meetings during the course of the hospital stay, the Treatment Team Social Worker (or designee), with input from the other members of the Treatment Team and CSB staff, shall revise the *Needs Upon Discharge* as follows:

- Indicate revisions by drawing one line through any items that are no longer needed and providing initials/date next to each change. Additional space is provided under each domain for ***Revisions/Updates***.
- Indicate items added at a later date by checking the relevant items and providing initials/date next to each addition. Additional space is provided under each domain for ***Revisions/Updates***.
- Sign and date the form each time it is revised in the designated spaces on page 6 of the combined *Needs Upon Discharge*/*Discharge Plan* form or page 3 of the *Needs Upon Discharge* form.
- Once all available space has been used, note further additions and revisions on the *Needs Upon Discharge/Discharge Plan Addendum* form (DMH 942E 1191), which provides additional space for changes (see III below).

Form Instructions for *Needs Upon Discharge*, *Discharge Plan*, and *Addendum*
(DMH 942E 1190, DMH 942I 1190F, DMH 942E 1190C and DMH 942E 1191)

II. *Discharge Plan* (DMH 942E 1190 or DMH 942E 1190C)

The CSB staff, with input from the other members of the Treatment Team, shall initiate the *Discharge Plan* at the time of the first Comprehensive Treatment Plan meeting. . If the CSB representative is not present at the Treatment Team meeting, the Treatment Team Social Worker (or designee) shall fax a copy of the *Needs Upon Discharge* to him within one (1) working day. After receipt of the *Needs Upon Discharge*, the CSB staff shall initiate the *Discharge Plan* based upon the needs identified as of the first CTP. CSB staff shall fax the *Discharge Plan* to the Treatment Team Social Worker within three (3) working days of the Comprehensive Treatment Plan meeting and mail the original. The Treatment Team Social Worker (or designee) shall put the faxed copy in the medical record, replacing it with the original when it is received.

At the initial CTP meeting (or upon receipt of the *Needs Upon Discharge)*, the CSB staff shall fill out the *Discharge Plan* as completely as possible based on the needs identified on the *Needs Upon Discharge*. Throughout the course of the hospital stay, as the individual's needs change, the CSB staff shall revise the *Discharge Plan* until such time as the discharge plan is finalized (i.e., all necessary services and providers have been identified).

If a CSB representative is not present at any TPR meeting, the Treatment Team Social Worker (or designee) shall fax a copy of the revised *Needs Upon Discharge* to him within one (1) working day. After receipt of the revised *Needs Upon Discharge*, the CSB staff shall revise the *Discharge Plan* as needed and return it to the facility within three (3) working days of the TPR meeting (as above).

The *Discharge Plan* shall be maintained in the *Comprehensive Treatment Planning* section of the individual's medical record. The *Discharge Plan* may be completed on computer file if desired.

Initiating the *Discharge Plan*:

At the initial CTP meeting (or upon receipt of the *Needs Upon Discharge*), the CSB staff, with input from the Treatment Team, shall initiate the *Discharge Plan* as follows:

In the **PRE-DISCHARGE** section:

- Under ***Anticipated Date of Discharge***, record the date the individual is anticipated to be ready for discharge. **Note**: If the individual is on a legal status in forensic services that does not allow (for security purposes) the disclosure of a discharge date, then indicate this in the Anticipated Discharge Date section of the form.
- Under ***Barriers to Discharge,*** list any circumstances that may delay or impede discharge, e.g., legal constraints, individual refuses to be discharged, etc.

In the **MEDICAL** section:

- Indicate the types of medical services to be provided upon discharge, including the name of the provider(s) and the frequency of the service.
- There must be a Primary Care Physician identified for routine health maintenance even if the individual is not anticipated to have any other medical needs.

In the **MEDICATION** section:

- Indicate the types of medication services to be provided upon discharge, including the name of the provider(s) and the frequency of the service. If the individual is anticipated to be able to obtain and administer his own medication, check "Self-Administration".
- If the individual is not anticipated to require medication, check "N/A" (Not Applicable).

Form Instructions for *Needs Upon Discharge, Discharge Plan,* and *Addendum* (DMH 942E 1190, DMH 942I 1190F, DMH 942E 1190C and DMH 942E 1191)

In the **SUBSTANCE ABUSE** section:

- Indicate the types of substance abuse services to be provided upon discharge, including the name of the provider(s) and the frequency/duration of the service.
- If the individual is not anticipated to require any substance abuse services, check "N/A" (Not Applicable).

In the **PSYCHIATRIC/THERAPEUTIC** section:

- Indicate the types of psychiatric/therapeutic services to be provided upon discharge, including the name of the provider(s) and the frequency of the service.
- If the individual is not anticipated to require any psychiatric/therapeutic services, check "N/A" (Not Applicable).

In the **DAILY LIVING** section:

- Under each sub-section (***Hygiene, Nutrition, Transportation, Shopping, Money Management, Leisure/Socialization, Employment, Education***), indicate the types of services planned to address the individual's daily living needs, including the name of the provider(s) and the frequency/duration of the service.
- If the individual is not anticipated to require any services under a particular sub-section, check "N/A" (Not Applicable).

In the **LEGAL** section:

- Under ***LAR needed in community?,*** specify whether individual needs a LAR in the community (circle "Yes" or "No"). If yes, specify the status of obtaining the LAR (e.g. "Applied"). If known, enter the name of the individual serving as LAR in the community, specify his/her relationship to the individual receiving services, and indicate the type of LAR (e.g. Legal Guardian)
- Indicate other services planned to address the individual's legal needs, including the name of the provider and a description of the service if applicable.

In the **FINANCIAL** section:

- Under ***SSI, SSDI, Medicaid, Medicare***, specify the status of each benefit *(Applied, Reconsideration, Appeal, Approved, Denied,* or *N/A*).
- Indicate other types of financial entitlements expected to be in place upon discharge, including relevant details (e.g., amount per month, application pending, etc.).

In the **HOUSING** section:

- Indicate the housing services to be provided upon discharge, including the name of the provider, the location of the housing, and a description of the placement.

In the **SUPERVISION** Section:

- Indicate the types of supervision to be provided upon discharge, including an explanation of the type/purpose of supervision, the name of the provider(s), and the frequency/duration of the supervision.
- If the individual is not anticipated to need any supervision, check "N/A" (Not Applicable).

In the **TRANSITION** section:

- Indicate the types of services planned to assist the individual in making the transition from state facility to community (e.g. Passes, Trial Visits).

Form Instructions for *Needs Upon Discharge*, *Discharge Plan*, and *Addendum* (DMH 942E 1190, DMH 942I 1190F, DMH 942E 1190C and DMH 942E 1191)

- If the individual is not anticipated to require a transition plan, check "N/A" (Not Applicable).

In the **CRISIS** section:

- Describe the crisis plan to be followed upon discharge. Attach additional pages if necessary.
- There must be at least a "routine" crisis plan specified for each individual, i.e. Individual given 24-hour crisis number to call in case of emergency.

In the **OTHER** section:

- Indicate any religious, cultural, and/or other services to be provided upon discharge including the name of the provider(s), the location, and the frequency/duration of the service.
- If the individual is not anticipated to require any other services, check "N/A" (Not Applicable).

In the **SIGNATURES** section:

- Sign and date the form in the designated spaces on page 6 of the combined *Needs Upon Discharge*/*Discharge Plan* form or page 3 of the *Needs Upon Discharge* form.
- Review the *Discharge Plan* with the individual receiving services and/or legal guardian/authorized representative and obtain their signatures in the designated spaces on page 6 (right-hand column) of the combined *Needs Upon Discharge*/*Discharge Plan* form or page 3 of the *Discharge Plan* form.

In the **ADDRESSOGRAPH** section:

- Stamp each page in the designated space at the bottom right of the page.

Updates & Revisions to the *Discharge Plan*:

At subsequent TPR meetings (or upon receipt of revised *Needs Upon Discharge*), the CSB staff, with input from the other members of the Treatment Team, shall revise the *Discharge Plan* as follows:

- Indicate revisions by drawing one line through any items that are no longer planned and providing initials/date next to each change. Additional space is provided under each domain for ***Revisions/Updates***.
- Indicate items added at a later date by checking the relevant items and providing initials/date next to each addition. Additional space is provided under each domain for ***Revisions/Updates***.
- Sign and date the form each time it is revised in the designated spaces on page 6 of the combined *Needs Upon Discharge*/*Discharge Plan* form or page 3 of the *Discharge Plan* form.
- Once all available space has been used, note further additions and revisions on the *Needs Upon Discharge/Discharge Plan Addendum* form (DMH 942E 1191), which provides additional space for changes (see III below).

Form Instructions for *Needs Upon Discharge*, *Discharge Plan*, and *Addendum* (DMH 942E 1190, DMH 942I 1190F, DMH 942E 1190C and DMH 942E 1191)

III. *Needs Upon Discharge/Discharge Plan Addendum* (DMH 942E 1191)

Once all available space has been used on the *Needs Upon Discharge* and *Discharge Plan*, facility and CSB staff shall document further additions and revisions to the *Needs Upon Discharge* and *Discharge Plan* on the *Needs Upon Discharge/Discharge Plan Addendum* (DMH 942E 1191), herein referred to as the *Addendum.*

The left-hand column of the *Addendum* is reserved for facility staff to document changes to the *Needs Upon Discharge*. Once the space on the *Needs Upon Discharge* has been used, the Treatment Team Social Worker (or designee) shall document any revisions to the *Needs Upon Discharge* on the *Addendum.* Each entry on the *Addendum* must include the name of the domain addressed (e.g. HOUSING, MEDICAL, LEGAL), a description of the new or revised need, the Signature/Title of the staff member making the change, and the Date the change was made. Facility staff shall also review each entry on the *Addendum* with the individual receiving services and/or legally authorized representative (LAR) and obtain their initials in the designated spaces on the form.

The right-hand column of the *Addendum* is reserved for CSB staff to document changes to the *Discharge Plan*. Once the space on the *Discharge Plan* has been used, the CSB staff shall document any revisions to the *Discharge Plan* on the *Addendum.* Each entry on the *Addendum* must include the name of the domain addressed (e.g. HOUSING, MEDICAL, LEGAL), a description of the new or revised service, the Signature/Title of the staff member making the change, and the Date the change was made. CSB staff shall also review each entry on the *Addendum* with the individual receiving services and/or legally authorized representative (LAR) and obtain their initials in the designated spaces on the form.

Additional *Addendum* forms shall be used if more space is needed. Facility/CSB staff shall number *Addendum* forms in the upper right corner of the form in the designated space for "Attachment # _____". The first *Addendum* shall be numbered Attachment #1, the second #2, the third #3, and so on.

All *Addendum* forms shall be maintained in the *Comprehensive Treatment Planning* section of the individual's medical record with the original *Needs Upon Discharge* and *Discharge Plan*.

NEEDS UPON DISCHARGE	DISCHARGE PLAN
PRE-DISCHARGE INFORMATION **Individual's Motivation for Discharge:** **1** *Not Motivated* **2** *Slightly Motivated* **3** *Ambivalent* **4** *Moderately Motivated* **5** *Highly Motivated* **Revised Motivation for Discharge** *(Initial and Date each entry)* 1. *Circle One* 1 2 3 4 5 *Initial/Date* _____ 2. *Circle One* 1 2 3 4 5 *Initial/Date* _____ 3. *Circle One* 1 2 3 4 5 *Initial/Date* _____ **Individual's Preferences upon Discharge**: _____ _____ _____ _____ **Anticipated Date of Discharge:**	**Anticipated Date of Discharge:** _____ **Revised Anticipated Date of Discharge** ***(Initial and Date each entry)*** 1. _____ *Initial/Date* _____ 2. _____ *Initial/Date* _____ 3. _____ *Initial/Date* _____ **Barriers to Discharge:** _____ _____ _____ _____
MEDICAL ❑ Assess Needs ❑ Routine Health Maintenance ❑ Medical follow-up for: 1. _____ *Frequency* _____ 2. _____ *Frequency* _____ 3. _____ *Frequency* _____ 4. _____ *Frequency* _____ 5. _____ *Frequency* _____ ❑ Lab Work for _____ *Frequency* _____ ❑ Lab Work for _____ *Frequency* _____ ❑ Other: _____ _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	Primary Care Physician: _____ *Specify providers for Medical needs listed at left :* ❑ N/A 1. _____ *Frequency* _____ 2. _____ *Frequency* _____ 3. _____ *Frequency* _____ 4. _____ *Frequency* _____ 5. _____ *Frequency* _____ ❑ Lab Work *(specify type)* _____ *Provider* _____ *Frequency* _____ ❑ Other: _____ _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____
MEDICATION ❑ Assess Needs ❑ No Needs (Independent or N/A) ❑ Weekly packaging of medications *(by pharmacy)* ❑ Prompts/Reminders, *How often?* _____ ❑ Observation, *How often?* _____ ❑ Medication Administration, *How often?* _____ ❑ Assistance with Medi-Planner, *How often?* _____ ❑ Education *(specify purpose)* _____ _____ _____ ❑ Other: _____ _____ _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	***Specify Provider/Frequency for each service below:*** ❑ N/A ❑ Self-Administration ❑ Medications packaged by pharmacy *Provider* _____ *Frequency* _____ ❑ Prompts/Reminders *Provider* _____ *Frequency* _____ ❑ Observation *Provider* _____ *Frequency* _____ ❑ Medication Administered *Provider* _____ *Frequency* _____ ❑ Assistance with Medi-Planner *Provider* _____ *Frequency* _____ ❑ Other Service(s): _____ *Provider* _____ *Frequency* _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____

ADDRESSOGRAPH

	NEEDS UPON DISCHARGE	DISCHARGE PLAN
SUBSTANCE ABUSE	❑ Assess Needs ❑ No Needs (Independent or N/A) ❑ SA Assessment/Evaluation ❑ Education ❑ On-going support to facilitate recovery ❑ Family/significant other education ❑ Acknowledge abuse ❑ Maintain sobriety ❑ Other:_____ _____ ❑ Other:_____ _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	***Specify Provider/Frequency/Duration of each service:*** ❑ N/A ❑ SA Assessment: *Provider*_____ *Frequency/Duration* _____ ❑ AA/NA Meetings: *Location*_____ *Frequency/Duration* _____ ❑ Intensive Outpatient: *Provider*_____ *Frequency/Duration* _____ ❑ SA Residential Treatment: *Provider*_____ *Frequency/Duration* _____ ❑ Other Service/Provider:_____ *Frequency/Duration* _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____
PSYCHIATRIC/THERAPEUTIC	❑ Assess Needs ❑ No Needs (Independent or N/A) ❑ Medication follow-up, *How often?* _____ ❑ Coordination of services ❑ On-going support to facilitate recovery ❑ On-going symptom management ❑ On-going risk assessment ❑ Family/significant other education ❑ Family/couples issues ❑ Anger/conflict management ❑ Interpersonal skills training ❑ Coping skills ❑ Special Issues to be addressed: _____ _____ _____ ❑ Other:_____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	***Specify Provider/Frequency for each service checked:*** ❑ N/A ❑ Medication Management *Provider*_____ *Frequency* _____ ❑ Case Management *Provider*_____ *Frequency* _____ ❑ Individual psychotherapy *Provider*_____ *Frequency* _____ ❑ Group therapy *Provider*_____ *Frequency* _____ ❑ Day Treatment/Partial Hospitalization *Provider*_____ *Frequency* _____ ❑ Couples/Family therapy *Provider*_____ *Frequency* _____ ❑ Other Service(s):_____ _____ _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____
DAILY LIVING	**Hygiene** ❑ No Needs (Independent) ❑ Assess Needs ❑ Education *(specify purpose)*_____ ❑ Prompts/Reminders, *How often?* _____ *Describe*_____ ❑ Periodic monitoring, *How often?* _____ *Describe*_____ ❑ Assistance, *How often?* _____ *Describe*_____ ❑ To be provided by others ❑ Other:_____	**Hygiene** ❑ N/A ❑ Education/Skills Training: *Provider*_____ *Frequency/Duration* _____ ❑ Prompts/Reminders: *Provider*_____ *Frequency/Duration* _____ ❑ Periodic Monitoring: *Provider*_____ *Frequency/Duration*_____ ❑ Assistance: *Provider*_____ *Frequency/Duration*_____ ❑ Other: _____ _____

ADDRESSOGRAPH

NEEDS UPON DISCHARGE	DISCHARGE PLAN
DAILY LIVING (continued)	
Nutrition ❑ No Needs (Independent)	**Nutrition** ❑ N/A
❑ Assess Needs	❑ Education/Skills Training: *Provider* _____
❑ Education *(specify purpose)* _____	*Frequency/Duration* _____
❑ Periodic monitoring, *How often?* _____	❑ Periodic Monitoring: *Provider* _____
Describe _____	*Frequency/Duration* _____
❑ Assistance, *How often?* _____	❑ Assistance: *Provider* _____
Describe _____	*Frequency/Duration* _____
❑ Meals prepared by others	❑ Meals Prepared by others *(specify):* _____
❑ Other Dietary Needs/Restrictions *(specify)* _____	*Frequency/Duration* _____
_____	❑ Other: _____
Transportation ❑ No Needs (Independent or N/A)	**Transportation** ❑ N/A
❑ Assess Needs	❑ Education/Skills Training: *Provider* _____
❑ Education *(specify purpose)* _____	*Frequency/Duration* _____
_____	❑ Assistance: *Provider* _____
❑ Skill development to use public transportation	*Frequency/Duration* _____
❑ Assistance, *How often?* _____	❑ Transported by others: *Provider* _____
Describe _____	*Frequency/Duration* _____
❑ To be transported by others	❑ Other: _____
❑ Other: _____	_____
_____	
Shopping ❑ No Needs (Independent or N/A)	**Shopping** ❑ N/A
❑ Assess Needs	❑ Education/Skills Training: *Provider* _____
❑ Education *(specify purpose)* _____	*Frequency/Duration* _____
❑ Periodic monitoring, *How often?* _____	❑ Periodic Monitoring: *Provider* _____
Describe _____	*Frequency/Duration* _____
❑ Assistance, *How often?* _____	❑ Assistance: *Provider* _____
Describe _____	*Frequency/Duration* _____
❑ To be provided by others	❑ Provided by others: *Provider* _____
❑ Other: _____	*Frequency/Duration* _____
Money Management ❑ No Needs (Independent or N/A)	**Money Management** ❑ N/A
Able to manage an allowance? *Yes No Needs Assessment*	❑ Education/Skills Training: *Provider* _____
❑ Education *(specify purpose)* _____	*Frequency/Duration* _____
❑ Periodic monitoring/assistance, *How often?* _____	❑ Periodic Monitoring: *Provider* _____
Describe _____	*Frequency/Duration* _____
_____	❑ Assistance: *Provider* _____
❑ Overall money management to be provided by others	*Frequency/Duration* _____
❑ Other: _____	❑ Representative Payee: *Provider* _____
_____	*Frequency/Duration* _____
Leisure/Socialization ❑ No Needs (Independent or N/A)	**Leisure/Socialization** ❑ N/A
❑ Assess Needs	❑ Education/Skills Training: *Provider* _____
❑ Education *(specify purpose)* _____	*Frequency/Duration* _____
❑ Social skills development	❑ Psycho-Social Rehabilitation/Clubhouse
❑ Activities planned by others	*Provider* _____
❑ Hobbies/Interests: _____	*Frequency/Duration* _____
_____	❑ Activities planned by others *(specify)*: _____
❑ Other: _____	*Frequency/Duration* _____
_____	❑ Other: _____

	NEEDS UPON DISCHARGE	DISCHARGE PLAN
DAILY LIVING (continued)	**Employment** ❑ No Needs (Independent or N/A) Interested in employment? *(circle) Yes No Needs Assessment* If *Yes*, goals:_____ Able to Work? *(circle) Yes No Needs Assessment* ❑ Assessment *(specify purpose)*_____ ❑ Education/Training/Skill Development *(specify purpose)* _____ ❑ Assistance *(describe)*_____ _____ ❑ Supervision *(describe)*_____ _____ ❑ Other:_____ **Education** ❑ No Needs (Independent or N/A) Under age 18? *(circle) Yes No* Highest grade completed_____ Interested in formal education? *Yes No Needs Assessment* If *Yes*, goals: _____ ❑ Assessment *(specify purpose)*_____ ❑ Attend school/college, *Grade level?* _____ ❑ Complete GED ❑ Special Needs *(specify)*: _____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	**Employment** ❑ N/A ❑ Education/Skills Training: *Provider*_____ *Frequency/Duration* _____ ❑ Vocational Rehabilitation: *Provider*_____ *Frequency/Duration* _____ ❑ Paid/Volunteer Employment: *Provider*_____ *Frequency/Duration* _____ ❑ Supportive Employment: *Provider*_____ *Frequency/Duration* _____ ❑ Job Coach: *Provider*_____ *Frequency/Duration* _____ ❑ Other:_____ **Education** ❑ N/A ❑ Assessment*(specify)*_____ *Provider*_____ *Frequency/Duration* _____ ❑ Attend school/college*(specify):*_____ *Frequency/Duration* _____ ❑ Complete GED*(specify):*_____ ❑ Other:_____ _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____
LEGAL	Competent to make decisions? *(circle) Yes No Minor* Has LAR in Facility? *Yes No* If *Yes*, name_____ Has LAR in Community? *Yes No* (continue below) If *No*, is LAR needed? *Yes No* (circle type needed below): *Legal Guardian Power of Attorney Advanced Directive Other* If *Yes*, name of LAR_____ (circle type below): *Legal Guardian Power of Attorney Advanced Directive Other* ***Other Legal Needs:*** ❑ Attorney *(specify)*_____ ❑ Pending Charges: _____ ❑ Coordination with probation/parole officer ❑ Conditional Release Plan approved by FRP/Courts ❑ Advocacy *(specify)*_____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	LAR needed in Community? *(circle) Yes No* If *Yes*, specify status: *Applied, date*_____ *Completed, date*_____N/A Name of LAR: _____ Relationship to individual: _____ Type of LAR *(circle type below):* *Legal Guardian Power of Attorney Advanced Directive Other* ❑ Other:_____ _____ ***Other Legal Services:*** ❑ Attorney *(specify name):* _____ ❑ Pending Legal Issues: _____ ❑ Parole/Probation *(specify name):* _____ ❑ Conditional Release plan Approved by FRP, *date* _____ ❑ Advocacy *(describe)*_____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____

ADDRESSOGRAPH

	NEEDS UPON DISCHARGE	DISCHARGE PLAN
FINANCIAL	***Specify status of benefits (applied, approved, not eligible, etc.)*** ❑ SSI $_____/*month* Status:_____ ❑ SSDI $_____/*month* Status:_____ ❑ Medicaid Type/Status: _____ ❑ Medicare: Part A&B Part A only Part B only Needs Application ❑ Family Support ❑ Food Stamps ❑ CSA funding ❑ General Relief ❑ Pension $_____/*month* ❑ VA Benefits_____ ❑ Special Project *(specify)*_____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	***Specify status of benefits (applied, approved, not eligible, etc.)*** ❑ SSI *$*_____/*month* Status:_____ ❑ SSDI*$*_____/*month* Status:_____ ❑ Medicaid Type/Status: _____ ❑ Medicare: Part A&B Part A only Part B only *Status?*_____ ❑ Family Support ❑ Food Stamps ❑ CSA funding ❑ General Relief ❑ Pension $_____/*month* ❑ VA Benefits_____ ❑ Special Project *(specify)*_____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____
HOUSING	❑ No Needs/Return to prior housing_____ ❑ Assess Needs ❑ Obtain new living situation ❑ Live alone ❑ Live with family/significant others_____ ❑ Live with others, *Maximum #?* _____ *Same Sex?* Yes No ❑ Must live in specific area *(specify)*_____ ❑ Special Conditions:_____ ❑ Other:_____ ❑ Other:_____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	***Specify Type of Housing:*** ❑ With Family/Significant Others ❑ Independent Apartment ❑ Assisted Living Facility (ALF) ❑ Supervised Apartment ❑ Residential Treatment Program ❑ Group Home ❑ Crisis Care Facility ❑ Nursing Home ❑ Transfer to inpatient facility ❑ Correctional Facility ❑ Other _____ ❑ Host Home/Foster Care ***Specify Provider/Location/Description of Service:*** _____ _____ _____ _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____
SUPERVISION	❑ Assess Needs ❑ No Needs ❑ Supervision 24 hours per day, 7 days per week Overnight staff must be *(circle) Awake* or *On-site* Individual must be supervised directly at all times? *Yes No* *Explain:* _____ _____ _____ ❑ Other Supervision *(specify hours/day, days/week, purpose, etc.)* _____ _____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____	***Specify Purpose/Provider/Frequency/Duration of Supervision*** ❑ N/A ❑ Supervision for *(specify)*_____ _____ *Provider*_____ *Frequency/Duration*_____ ❑ Supervision for *(specify)*_____ _____ *Provider*_____ *Frequency/Duration*_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ _____ ❑ _____

ADDRESSOGRAPH

	NEEDS UPON DISCHARGE	DISCHARGE PLAN
TRANSITION	Need for Transition to Community? *Yes* *No* *Needs Assessment* If *Yes*, specify needs_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ ❑ _____	***Transition Plan*** ***(list provider/frequency/duration/dates):*** ❑ N/A **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ ❑ _____
CRISIS	Need for Specialized Crisis Plan? *Yes* *No (routine plan)* *Specify Issues to be addressed:*_____	***Crisis Plan*** ***(attach additional pages as needed)***_____
OTHER	❑ Assess Needs ❑ No Needs ❑ Religious *(describe)*_____ ❑ Cultural *(describe)*_____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ ❑ _____	***Describe other services to be provided below:*** ❑ N/A ❑ Religious _____ ❑ Cultural _____ ❑ Other:_____ **Revisions/Updates** *(Initial and Date each entry)* ❑ _____ ❑ _____
SIGNATURES	**Completed by (facility staff):** _____ *Signature* *Title* *Date* **Revisions/Updates (facility staff):** _____ *Initials/Signature* *Title* *Date* _____ *Initials/Signature* *Title* *Date* _____ *Individual Receiving Services* *Date* _____ *Legally Authorized Representative* *Date*	**Completed by (CSB staff):** _____ *Signature* *Title* *Date* **CSB:** _____ **Revisions/Updates (CSB staff):** _____ *Initials/Signature* *Title* *Date* _____ *Initials/Signature* *Title* *Date* _____ *Individual Receiving Services* *Date* _____ *Legally Authorized Representative* *Date*

ADDRESSOGRAPH

DISCHARGE PLAN

PRE-DISCHARGE

Anticipated Date of Discharge: _____

Revised Anticipated Date of Discharge ***(Initial and Date each entry)***

1. _____ *Initial/Date* _____
2. _____ *Initial/Date* _____
3. _____ *Initial/Date* _____

Barriers to Discharge:

_____
_____
_____
_____

MEDICAL

Primary Care Physician: _____

❑ Lab Work *(specify type)* _____
_____
Provider _____ *Frequency* _____

❑ Other: _____
_____

Specify providers for Medical needs: ❑ N/A

1. _____ *Frequency* _____
2. _____ *Frequency* _____
3. _____ *Frequency* _____
4. _____ *Frequency* _____
5. _____ *Frequency* _____

Revisions/Updates *(Initial and Date each entry)*

❑ _____
❑

MEDICATION

Specify Provider/Frequency for each service below: ❑ N/A

❑ Self-Administration
❑ Medications packaged by pharmacy
Provider _____ *Frequency* _____
❑ Prompts/Reminders
Provider _____ *Frequency* _____
❑ Observation
Provider _____ *Frequency* _____
❑ Medication Administered
Provider _____ *Frequency* _____
❑ Assistance with Medi-Planner
Provider _____ *Frequency* _____
❑ Other Service(s): _____
Provider _____ *Frequency* _____

Revisions/Updates *(Initial and Date each entry)*

❑ _____
❑

SUBSTANCE ABUSE

Specify Provider/Frequency/Duration of each service: ❑ N/A

❑ SA Assessment: *Provider* _____
Frequency/Duration _____
❑ AA/NA Meetings: *Location* _____
Frequency/Duration _____
❑ Intensive Outpatient: *Provider* _____
Frequency/Duration _____
❑ SA Residential Treatment: *Provider* _____
Frequency/Duration _____
❑ Other Service/Provider: _____
Frequency/Duration _____

Revisions/Updates *(Initial and Date each entry)*

❑ _____
❑

PSYCHIATRIC/THERAPEUTIC

Specify Provider/Frequency for each service checked: ❑ N/A

❑ Medication Management
Provider _____ *Frequency* _____
❑ Case Management
Provider _____ *Frequency* _____
❑ Individual psychotherapy
Provider _____ *Frequency* _____
❑ Group therapy
Provider _____ *Frequency* _____
❑ Day Treatment/Partial Hospitalization
Provider _____ *Frequency* _____
❑ Couples/Family therapy
Provider _____ *Frequency* _____
❑ Other Service(s): _____
_____
_____

Revisions/Updates *(Initial and Date each entry)*

❑ _____
❑

ADDRESSOGRAPH

DISCHARGE PLAN

DAILY LIVING

Hygiene ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Prompts/Reminders: *Provider*_____
  Frequency/Duration _____
- ❑ Periodic Monitoring/Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Other: _____

Nutrition ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Periodic Monitoring/Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Meals Prepared by others *(specify):*_____
  *Frequency/Duration*_____
- ❑ Other:_____

Transportation ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Transported by others: *Provider*_____
  *Frequency/Duration*_____
- ❑ Other:_____

Shopping ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Periodic Monitoring/Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Provided by others: *Provider*_____
  *Frequency/Duration*_____
- ❑ Other:_____

Money Management ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Periodic Monitoring/Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Representative Payee: *Provider*_____
  *Frequency/Duration*_____
- ❑ Other:_____

Leisure/Socialization ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ PSR/Clubhouse: *Provider*_____
  *Frequency/Duration*_____
- ❑ Activities planned by others *(specify)*:_____
  *Frequency/Duration*_____
- ❑ Other:_____

Employment ❑ N/A

- ❑ Education/Skills Training/Vocational Rehabilitation:
  *Provider*_____
  Frequency/Duration _____
- ❑ Paid/Volunteer Employment: *Provider*_____
  Frequency/Duration _____
- ❑ Supportive Employment/ Job Coach: _____
  Frequency/Duration _____
- ❑ Other:_____

Education ❑ N/A

- ❑ Assessment*(specify)*_____
  *Provider*_____
  Frequency/Duration _____
- ❑ Attend school/college*(specify):*_____
  Frequency/Duration _____
- ❑ Complete GED*(specify):*_____
- ❑ Other:_____
  _____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

LEGAL

LAR needed in Community? *(circle) Yes No*

If *Yes*, specify status: *Applied, date*_____ *Completed, date*_____ N/A

Name of LAR: _____

Relationship to individual: _____

Type of LAR *(circle type below):*

Legal Guardian Power of Attorney Advanced Directive Other

- ❑ Other:_____

Other Legal Services:

- ❑ Attorney *(specify name):* _____
- ❑ Pending Legal Issues: _____
- ❑ Parole/Probation *(specify name):* _____
- ❑ Conditional Release plan Approved by FRP, *date* _____
- ❑ Advocacy *(describe)*_____
- ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

ADDRESSOGRAPH

DISCHARGE PLAN

FINANCIAL

Specify status of benefits (applied, approved, not eligible, etc.)

- ❑ SSI *$_____/month* Status: _____
- ❑ SSDI*$_____/month* Status: _____
- ❑ Medicaid Type/Status: _____
- ❑ Medicare: Part A&B Part A only Part B only *Status?*_____
- ❑ Family Support
- ❑ CSA funding
- ❑ Pension $_____/*month*
- ❑ Special Project *(specify)*_____
- ❑ Other:_____
- ❑ Food Stamps
- ❑ General Relief
- ❑ VA Benefits_____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

HOUSING

Specify Type of Housing:

- ❑ With Family/Significant Others
- ❑ Assisted Living Facility (ALF)
- ❑ Residential Treatment Program
- ❑ Crisis Care Facility
- ❑ Transfer to inpatient facility
- ❑ Independent Apartment
- ❑ Supervised Apartment
- ❑ Group Home
- ❑ Nursing Home
- ❑ Correctional Facility
- ❑ Host Home/Foster Care
- ❑ Other _____

Specify Provider/Location/Description of Service:_____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

SUPERVISION

Specify Purpose/Provider/Frequency/Duration of Supervision ❑ N/A

❑ Supervision for *(specify)*_____

*Provider*_____ *Frequency/Duration* _____

❑ Supervision for *(specify)*_____

*Provider*_____ *Frequency/Duration* _____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

TRANSITION

Transition Plan ***(list provider/frequency/duration/dates):*** ❑ N/A

_____

_____

_____

CRISIS

Crisis Plan ***(attach additional pages as needed)***_____

_____

OTHER

Describe other services to be provided below: ❑ N/A

❑ Religious _____ ❑ Cultural _____ ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

SIGNATURES

Completed by (CSB staff):

_____

Signature *Title* *Date*

CSB: _____

_____

Individual Receiving Services *Date*

Revisions/Updates (CSB staff):

_____

Initials/Signature *Title* *Date*

_____

Initials/Signature *Title* *Date*

_____

Legally Authorized Representative *Date*

ADDRESSOGRAPH

NEEDS UPON DISCHARGE

PRE-DISCHARGE

Individual's Motivation for Discharge:

1	2	3	4	5
Not Motivated	*Slightly Motivated*	*Ambivalent*	*Moderately Motivated*	*Highly Motivated*

Anticipated Date of Discharge: _____

Revised Motivation for Discharge *(Initial and Date each entry)*

1. *Circle One* 1 2 3 4 5 *Initial/Date* _____
2. *Circle One* 1 2 3 4 5 *Initial/Date* _____
3. *Circle One* 1 2 3 4 5 *Initial/Date* _____

Revised Anticipated Date of Discharge: _____

Individual's Preferences upon Discharge: _____

_____

MEDICAL

- ❑ Assess Needs
- ❑ Routine Health Maintenance
- ❑ Lab Work for _____ *Frequency*_____
- ❑ Lab Work for _____ *Frequency*_____
- ❑ Other: _____
  _____
  _____
- ❑ Medical Follow-up for *(specify below)*:
  1. _____*Frequency*_____
  2. _____*Frequency*_____
  3. _____*Frequency*_____
  4. _____*Frequency*_____
  5. _____*Frequency*_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

MEDICATION

- ❑ Assess Needs
- ❑ No Needs (Independent or N/A)
- ❑ Weekly packaging of medications *(by pharmacy)*
- ❑ Assistance with Medi-Planner, *How often?* _____
- ❑ Prompts/Reminders, *How often?* _____
- ❑ Education *(specify purpose)* _____
  _____
- ❑ Observation, *How often?* _____
- ❑ Medication Administration, *How often?* _____
- ❑ Other: _____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

SUBSTANCE ABUSE

- ❑ Assess Needs
- ❑ No Needs (Independent or N/A)
- ❑ SA Assessment/Evaluation
- ❑ Family/significant other education
- ❑ Education
- ❑ Acknowledge abuse
- ❑ On-going support to facilitate recovery
- ❑ Maintain sobriety
- ❑ Other: _____
- ❑ Other: _____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

PSYCHIATRIC/THERAPEUTIC

- ❑ Assess Needs
- ❑ No Needs (Independent or N/A)
- ❑ Medication follow-up, *How often?* _____
- ❑ Family/significant other education
- ❑ Coordination of services
- ❑ Family/couples issues
- ❑ On-going support to facilitate recovery
- ❑ Anger/conflict management
- ❑ On-going symptom management
- ❑ Interpersonal skills training
- ❑ On-going risk assessment
- ❑ Coping skills
- ❑ Special Issues to be addressed : _____
- ❑ Other: _____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

ADDRESSOGRAPH

NEEDS UPON DISCHARGE

DAILY LIVING

Hygiene ❑ No Needs (Independent)

- ❑ Assess Needs
- ❑ Education *(specify purpose)*_____
- ❑ Prompts/Reminders, *How often?* _____
  *Describe*_____
- ❑ Periodic monitoring/assistance, *How often?* _____
  *Describe*_____
- ❑ To be provided by others
- ❑ Other:_____

Transportation ❑ No Needs (Independent or N/A)

- ❑ Assess Needs
- ❑ Education *(specify purpose)* _____
- ❑ Skill development to use public transportation
- ❑ Assistance, *How often?* _____
  *Describe*_____
- ❑ To be transported by others
- ❑ Other:_____

Money Management ❑ No Needs (Independent or N/A)

Able to manage an allowance? *Yes No Needs Assessment*

- ❑ Education *(specify purpose)*_____
- ❑ Periodic monitoring/assistance, *How often?* _____
  *Describe*_____
- ❑ Overall money management to be provided by others
- ❑ Other:_____

Employment ❑ No Needs (Independent or N/A)

Interested in employment? *(circle) Yes No Needs Assessment*
If *Yes*, goals:_____

Able to Work? *(circle) Yes No Needs Assessment*

- ❑ Assessment *(specify purpose)* _____
- ❑ Education/Training/Skill Development *(specify purpose)*
  _____
- ❑ Assistance *(describe)*_____
- ❑ Supervision *(describe)*_____
- ❑ Other:_____

Nutrition ❑ No Needs (Independent)

- ❑ Assess Needs
- ❑ Education *(specify purpose)* _____
- ❑ Periodic monitoring/assistance, *How often?* _____
  Describe _____
  _____
- ❑ Meals prepared by others
- ❑ Other Dietary Needs/Restrictions *(specify)* _____
  _____

Shopping ❑ No Needs (Independent or N/A)

- ❑ Assess Needs
- ❑ Education *(specify purpose)* _____
- ❑ Periodic monitoring/assistance, *How often?* _____
  Describe _____
- ❑ To be provided by others
- ❑ Other:_____
  _____

Leisure/Socialization ❑ No Needs (Independent or N/A)

- ❑ Assess Needs
- ❑ Education *(specify purpose)*_____
- ❑ Social skills development
- ❑ Activities planned by others
- ❑ Hobbies/Interests:_____
- ❑ Other:_____

Education ❑ No Needs (Independent or N/A)

Under age 18? *(circle) Yes No*
Highest grade completed: _____
Interested in formal education? *Yes No Needs Assessment*
If *Yes*, goals: _____

- ❑ Assessment *(specify purpose)*_____
- ❑ Attend school/college, *Grade level?* _____
- ❑ Complete GED
- ❑ Special Needs *(specify)*: _____
- ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

LEGAL

Competent to make decisions? *(circle) Yes No Minor*
Has LAR in Facility? *Yes No* If *Yes*, name_____
Has LAR in Community? *Yes No* (continue below)
If *No*, is LAR needed? *Yes No* (circle type needed below):
Legal Guardian Power of Attorney Advanced Directive Other
If *Yes*, name of LAR_____ (circle type below):
Legal Guardian Power of Attorney Advanced Directive Other

Other Legal Needs:

- ❑ Attorney *(specify)*_____
- ❑ Pending Charges: _____
- ❑ Coordination with probation/parole officer
- ❑ Conditional Release Plan approved by FRP/Courts
- ❑ Advocacy *(specify)*_____
- ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

ADDRESSOGRAPH

NEEDS UPON DISCHARGE

FINANCIAL

Specify status of benefits (applied, approved, not eligible, etc.)

- ❑ SSI $_____/*month* Status:_____
- ❑ SSDI $_____/*month* Status:_____
- ❑ Medicaid Type/Status: _____
- ❑ Medicare: Part A&B Part A only Part B only Needs Application
- ❑ Family Support
- ❑ CSA funding
- ❑ Pension $_____/*month*
- ❑ Special Project *(specify)* _____
- ❑ Other:_____
- ❑ Food Stamps
- ❑ General Relief
- ❑ VA Benefits_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

HOUSING

- ❑ No Needs/Return to prior housing_____
- ❑ Assess Needs
- ❑ Obtain new living situation
- ❑ Special Conditions:_____
- ❑ Live alone
- ❑ Live with family/significant others_____
- ❑ Live with others, *Maximum #?* _____ *Same Sex?* Yes No
- ❑ Must live in specific area *(specify)*_____
- ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

SUPERVISION

- ❑ Assess Needs
- ❑ No Needs
- ❑ Supervision 24 hours per day, 7 days per week/Overnight staff must be *(circle) Awake* or *On-site*

Individual must be supervised directly at all times? *Yes No Explain:* _____

_____

- ❑ Other Supervision *(specify hours/day, days/week, purpose, etc.)* _____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

TRANSITION

Need for Transition to Community? *(circle) Yes No Needs Assessment* If Yes, specify needs below:

_____

_____

_____

CRISIS

Need for Specialized Crisis Plan? *(circle) Yes No (routine plan)* Specify issues to be addressed below:

_____

OTHER

- ❑ Assess Needs
- ❑ No Needs
- ❑ Religious:_____
- ❑ Cultural:_____
- ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

SIGNATURES

Completed by (facility staff):

_____

Signature Title Date

_____

Individual Receiving Services Date

_____

Legally Authorized Representative Date

Revisions/Updates (facility staff):

_____

Initials/Signature Title Date

_____

Initials/Signature Title Date

_____

Initials/Signature Title Date

ADDRESSOGRAPH

Attachment # __________

Needs Upon Discharge/Discharge Plan Addendum

Needs Upon Discharge	Discharge Plan
Specify domain:	***Specify domain:***
Completed by (facility staff):	**Completed by (CSB staff):**
Signature Title Date	Signature Title Date
Consumer/LAR initials: *Date:*	*Consumer/LAR initials:* *Date:*

Needs Upon Discharge	Discharge Plan
Specify domain:	***Specify domain:***
Completed by (facility staff):	**Completed by (CSB staff):**
Signature Title Date	Signature Title Date
Consumer/LAR initials: *Date:*	*Consumer/LAR initials:* *Date:*

Needs Upon Discharge	Discharge Plan
Specify domain:	***Specify domain:***
Completed by (facility staff):	**Completed by (CSB staff):**
Signature Title Date	Signature Title Date
Consumer/LAR initials: *Date:*	*Consumer/LAR initials:* *Date:*

Needs Upon Discharge	Discharge Plan
Specify domain:	***Specify domain:***
Completed by (facility staff):	**Completed by (CSB staff):**
Signature Title Date	Signature Title Date
Consumer/LAR initials: *Date:*	*Consumer/LAR initials:* *Date:*

Department of Mental Health, Mental Retardation and Substance Abuse Services Needs Upon Discharge/Discharge Plan Addendum DMH 942E 1191 10/30/01 Page 1 of 1	ADDRESSOGRAPH

ATTACHMENT 2

Crisis Plan Template

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Crisis Plan Template

I. BASIC DEMOGRAPHIC INFORMATION

A. Name of individual receiving services
B. Current providers (public and private)
C. Legally Authorized Representative (if applicable)
D. Current medications

II. BACKGROUND (include rationale for crisis plan)

(e.g., excessive admissions to hospital, high user of emergency services, self injurious behavior)

III. CRISIS "SCRIPT" (characteristics)

A. What factors contribute to increased risk or decompensation?
(*e.g., rejection, medication changes, family visits, holiday, and decline in health*)

B. What are the warning signs that indicate the individual may be heading towards a crisis? *(e.g., increased isolation, neglecting self-care, spending spree, substance use)*

C. What is this individual's typical pattern of decompensation or pattern of heightened risk? *(Describe in as much detail as is possible)*

D. What factors seem to help in reducing risk or maintaining stability?

E. What can individual try to do?

F. What can others try to do*?*

IV. CRISIS PLAN

A. BASELINE: Specify measures that are in place to maintain stability and prevent decompensation.
B. PRE-CRISIS: In response to warning signs, specify measures to be taken to reinforce stability and reduce the risk of decompensation.
   (1) Who might be available to assist?
   (2) Who should be contacted?
   (3) Who should not be contacted?
   (4) What has worked well in the past? *(e.g., increase phone contact, respite stay, medication evaluation, contact therapist, friend or family, added structure)*
C. CRISIS:
   If situation develops into a crisis, specify actions to be taken to handle crisis (hospital, police, one to one staff, particular hospital to avoid or pursue, detox) *Who, What, When, Where and How* **must be delineated.**

V. SIGNATURES/AUTHORIZATIONS: Ensure all releases of information have been obtained and that all participating parties have signed and endorsed the Crisis Plan.

VI. DISTRIBUTION LIST

Please list Name, Position and/or Affiliation of all parties to receive copies of the Crisis Plan.

ATTACHMENT 3

Discharge Information and Instructions Form
(DMH 942I 0226)

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Discharge Information and Instruction Form

Facility ❑ Catawba ❑ CSH ❑ CCCA ❑ ESH ❑ NVMHI ❑ Piedmon ❑ SVMHI ❑ SwVMHI ❑ WSH

Name: ____ **Registration Number:** _ _ _ _ _ _-_ _ _ _

Legally Authorized Representative: ____________________________________ **Relationship:** _______________________

Case Management CSB: ______________________________ **Discharge CSB:** ________________________ _ _ _ _
(PRAIS CSB Code)

Admission Date: _ _/_ _/_ _ **Discharge Date:** _ _/_ _/_ _ **Date of Birth:** _ _/_ _/_ _

SSN: _ _ _-_ _-_ _ _ _ **Discharge Phone:** (_ _ _) _ _ _-_ _ _ _ **Ext.** ____________

Discharge Address: ____

Type of Placement: ____ **Placement Code:** _ _ _ _
(PRAIS Out Referral Code)

Signed Authorization to Release Information to Private Provider: ***Yes*** ***No*** ***N/A***

CSB Case Manager: ___________________________________ **Phone:** (_ _ _) _ _ _-_ _ _ _ **Ext.** _______

CSB Emergency Services Phone: (_ _ _) _ _ _-_ _ _ _ **Ext.** _________

First Appointment: DATE: _ _/_ _/_ _ TIME: _ _:_ _AM/PM

Provider Type: ❑ case manager ❑ therapist ❑ psychiatrist ❑ other (specify): ________________________

Provider's Name: ____

Provider's Address: ____

Provider's Phone: (_ _ _) _ _ _-_ _ _ _ Ext. __________

Other Appointment: DATE: _ _/_ _/_ _ TIME: _ _:_ _AM/PM

Provider Type: ❑ case manager ❑ therapist ❑ psychiatrist ❑ other (specify): ________________________

Provider's Name: ____

Provider's Address: ____

Provider's Phone: (_ _ _) _ _ _-_ _ _ _ Ext. __________

Other Appointment: DATE: _ _/_ _/_ _ TIME: _ _:_ _AM/PM

Provider Type: ❑ case manager ❑ therapist ❑ psychiatrist ❑ other (specify): ________________________

Provider's Name: ____

Provider's Address: ____

Provider's Phone: (_ _ _) _ _ _-_ _ _ _ Ext. __________

Other Information:

____

____

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Discharge Information and Instruction Form

Name: _____ **Registration Number:** _ _ _ _ _ _ - _ _ _ _

DISCHARGE DIAGNOSES

Axis I

Axis II

Axis III

Axis IV

Axis V *Current:* _____ *Highest in Past Year:* _____

Condition on Release: ❑ *Recovered* ❑ *Not Recovered, Improved* ❑ *Unimproved* ❑ *Not Mentally Ill*

DISCHARGE MEDICATIONS

MEDICATION NAME	REGIMEN	# PILLS GIVEN

Date Pharmacy Card Mailed __ __/__ __/__ __ or *N/A* **Prescriptions Written:** *Yes* *No* *N/A*

Other Information:

MD Signature:	**Date:**

ADDRESSOGRAPH

Discharge Information and Instruction Form

Name: _____ **Registration Number:** _ _ _ _ _ _-_ _ _ _

Additional Discharge Instructions:

Crisis Plan: *(CSB attach detailed crisis plan as needed)*

Signatures:

Facility Staff	***Date***	***CSB Staff***	***Date***

I, the undersigned, have reviewed this Discharge Information and Instruction Form*. I understand that this document will be transmitted to the CSB(s) providing and/or overseeing my services in the community.*

Individual Receiving Services /Date

Legal Guardian/Date	***Authorized Representative/Date***

ADDRESSOGRAPH