

Consumer Name: _____

Service Record # _____

Date the Child and Family Team met to develop this discharge/transition plan: __/__/__

Division of MH/DD/SAS
Division of Medical Assistance

Child/Adolescent Discharge/Transition Plan

This document must be submitted with the completed ITR, the required PCP (i.e. introductory, complete or update) and any other supporting documentation justifying the request for authorization and reauthorization of Residential Levels III and IV. In addition, for reauthorization of Residential Level III and IV, a new comprehensive clinical assessment by a psychiatrist (independent of the residential provider and its provider organization) that includes clinical justification for continued stay at that level of care is required to be submitted. This document is also required for an initial care review for a PRTF only. An incomplete ITR, PCP or lack of Discharge/Transition Plan and a new comprehensive clinical assessment (when applicable) will result in a request being "unable to process".

I. The recipient's expected discharge date from the following service is:

- Residential Level III Expected Discharge Date: __/__/__
- Residential Level IV Expected Discharge Date: __/__/__
- PRTF Date of Initial Care Review Only: __/__/__

II. At time of discharge the recipient will transition and/or continue with the following services. Please indicate both the planned date of admission to each applicable service and the anticipated provider.

- Natural and Community Supports (Provide details in Section III.)
- Outpatient Individual Therapy __/__/__ Provider: _____
- Outpatient Family Therapy __/__/__ Provider: _____
- Outpatient Group Therapy __/__/__ Provider: _____
- Medication Management __/__/__ Provider: _____
- Respite __/__/__ Provider: _____
- Intensive In-Home __/__/__ Provider: _____
- Multisystemic Therapy __/__/__ Provider: _____
- Substance Abuse Intensive Outpatient __/__/__ Provider: _____
- Day Treatment __/__/__ Provider: _____
- Level II Program Type __/__/__ Provider: _____
- Therapeutic Foster Care __/__/__ Provider: _____
- PRTF __/__/__ Provider: _____
- Other __/__/__ Provider: _____
- Other __/__/__ Provider: _____
- Other __/__/__ Provider: _____

III. The Child and Family Team has engaged the following natural and community supports to both build on the strengths of the recipient and his/her family and meet the identified needs.

- | | | |
|-------------------|-------------|----------------|
| Name/Agency _____ | Role: _____ | Date: __/__/__ |
| Name/Agency _____ | Role: _____ | Date: __/__/__ |
| Name/Agency _____ | Role: _____ | Date: __/__/__ |
| Name/Agency _____ | Role: _____ | Date: __/__/__ |

IV. Input into the Person-Centered Plan developed by the Child and Family Team was received from the following (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Recipient | <input type="checkbox"/> MH/SA TCM Provider |
| <input type="checkbox"/> Family/Caregivers | <input type="checkbox"/> Court Counselor |
| <input type="checkbox"/> Natural Supports | <input type="checkbox"/> School (all those involved) |
| <input type="checkbox"/> Community Supports (e.g. civic & faith based organizations) | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Local Management Entity | <input type="checkbox"/> Medical provider |
| <input type="checkbox"/> Residential Provider | <input type="checkbox"/> Other _____ |

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V. Please explain your plan for transition to new services and supports (i.e. engaging natural and community supports, identification of new providers, visits home or to new residence, transition meetings with new providers, etc.) Who will do what by when?

Activity	Responsible Party	Implementation Date

VI. The Child and Family Team updated the Crisis Plan as part of the PCP Revision to include issues of safety at home, at school and in the community.

Yes No

Please explain: _____

VII. For recipients identified as high risk for dangerous or self injurious behaviors the discharge/transition plan includes admission to the appropriate level of care.

Yes No

Please explain: _____

VIII. The Child and Family Team has identified and addressed the following potential barriers to success of the discharge/transition plan.

IX. The Child and Family Team will meet again on ____/____/____ in order to follow-up on the discharge/transition plan and address potential barriers.

X. Required Signatures

Recipient _____ Date ____/____/____

Legally Responsible Person _____ Date ____/____/____

Qualified Professional _____ Date ____/____/____
(Person responsible for the PCP)

<input type="checkbox"/> I agree with the Child and Family Team recommendation. <input type="checkbox"/> I do not agree with the Child and Family Team recommendation. (*Please note signature below is required by SOC regardless of agreement with recommendation. Signature does not indicate agreement or disagreement of Child and Family Team recommendation, merely review of discharge plan.) LME SOC/Representative _____ Date ____/____/____ (Required for residential requests only)
