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. 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: ___/___/___

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):

☐ Recipient

☐ Family/Caregivers

☐ Natural Supports

☐ Community Supports (e.g. civic & faith based organizations)

☐ Local Management Entity

☐ Residential Provider

☐ MH/SA TCM Provider

☐ Court Counselor

☐ School (all those involved)

☐ Social Services

☐ Medical provider

☐ Other________________________
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)

□ I agree with the Child and Family Team recommendation.
□ 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)