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. 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_____

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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_____ResponsibleParty_____ImplementationDate_____

_____
_____
_____
_____
_____

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)