**This form is not for claiming, service must be documented in a progress note in order to be claimed**

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| --- |
| **Discharge Plan** |
| Client: |   |   |   |
|  | InSyst # | Last Name | First Name |
| Location: |   | Episode Opening Date: |   |
| Agency: |   | RU: |   |
| Services were provided in:  |   | by [ ]  interpreter or [ ]  clinician |
|  |  |  |
| **Plan** |
| **DISCHARGE/SUPPORT PLAN** |
| The discharge plan must be completed with the client and the counselor or therapist within 30 days prior to completion of treatment services. |
| The following is my personalized Continuing Care Plan for my on-going recovery and support. Before completing treatment for my addiction I will present this Continuing Care Plan to someone within my support network such as my sponsor, other peers, mentor or spiritual advisor and receive thoughtful feedback, suggestions and comments about My Plan. |
| Episode Opening Date: |   | Episode Closing Date: |   | Date of Last Face-To-Face: |   |
| This treatment program has my permission to contact me during the next 12 months as a follow-up to my treatment and recovery: [ ]  Yes [ ]  No |
| Client Initial:  |   | Best Contact/Email:  |   | Phone: |   |
| I will attend Recovery Support Services: | Day: |   | Time: |   | Counselor: |   |
| **12 STEP AND/OR OTHER SUPPORT NETWORK:** I plan to attend the following weekly meetings: |
| **Day(s)** | **Location** | **Time** | **Description or Program Name** |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| **SPONSOR, MENTOR, SPIRITUAL ADVISOR OR OTHER SUPPORT PERSON:** |
| Name of Support Person:  |
| I WILL MEET WITH THEM: [ ]  Daily [ ]  Weekly [ ]  Monthly [ ]  Other:  |
| **Description of this commitment:**  |
| **SUPPORT GROUP COMMITMENTS** (e.g. Community or Other Volunteer Services-Hospitals & Institutions, Coffee Maker, Religious/Spiritual). Describe:  |
| **ADDITIONAL SUPPORT** (individual therapy, medical/physical health needs, outside groups, social activities):I have identified the following activities as an important part of my recovery. Describe:  |
| **RELAPSE PREVENTION AND WARNING SIGNS** (e.g. isolation, missed meetings, missed medications, failure, success, anxiety, anger, depression,-people, places or things that jeopardize my recovery): |
|   |
| **Relapse Triggers/Warning Signs Are:** | **My Action Plan Is:** |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |
| **ADDITIONAL NEEDS FOR MY RELAPSE PREVENTION PLAN:** (I have identified the following goals or issues as I continue to participate in my recovery (housing, employment, sponsorship, child care, transportation): |
|   |
| **Name of Person** | **Telephone #** |
|   |   |
|   |   |
|   |   |
| **MY VISION FOR RECOVERY:**   |
| **As a person in recovery I understand that neglecting my recovery plan will jeopardize my ability to maintain my recovery. I know that addiction is a chronic condition. I know how important it is that I maintain a recovery plan that includes a strong support system with people who care for me.** |
| Time in Recovery as of this date: |   | Recovery Date: |   |
| My comments regarding treatment, such as: emotional highpoints; low points; & pivotal insights as a result of treatment: |
|   |
| **Instructions:** Based on the my most recent treatment plan Goals & Objectives, I will continue to work on the following: |
| **Index #** | **Stage** | **My Continuing Goals** |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
| Was I advised of CCR 22 Sec 51341.1 Fair Hearing Rights if the discharge was due to loss of Medi-Cal benefits? [ ]  Yes [ ]  NoProviders must inform each beneficiary in writing, at least ten (10) calendar days prior to the effective date of the intended action to terminate or reduce services, of the right to a fair hearing related to denial, involuntary discharge, or reduction in DMC substance use disorder services as it relates to their loss of eligibility or reduction of benefits, pursuant to Section 50951.**To request a hearing contact:**Department of Social Services: State Hearing Division P.O. Box 944243,M.S. 9-17-37 Sacramento, CA 94244-2430Oral Requests by Telephone: 1-800-952-5253 TDD – 1-800-952-8349 |
| **Counselor/Therapist Summary of the Treatment Episode:** |
| Prognosis (select one): [ ]  Excellent [ ]  Good [ ]  Fair [ ]  Poor [ ]  Guarded [ ]  Unstable |
| **Describe prognosis and further treatment recommendations):**   |
| **Discharge Summary Codes - Administrative - Table A** |
| **Percent (%) of Tx Plan Goals Achieved** | **Discharge Status Code and Description** |
| [ ]  100 - 75% | 1. Completed Tx/Recovery Plan Goals - Referred |
| [ ]  100 – 75% | 2. Completed Treatment/Recovery Plan Goals - Not Referred |
| [ ]  75 – 50% | 3. Left Before Completion with Satisfactory Progress - Referred |
| [ ]  < 50% | 5. Left Before Completion with Unsatisfactory Progress - Referred |
| Client Received a Copy: [ ]  Yes [ ]  No If no, must explain why:  |
| [ ]  Provider attests that the individual signed on this date:  |

|  |  |  |
| --- | --- | --- |
|  |   |  |
| Client Signature (required) | Printed Name/Credentials | Date |
|  |   |  |
| SUD Counselor/LPHA (required) | Printed Name/Credentials | Date |