DISCHARGE 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.

Admission Date: _____

Client Name: _____ Today's Date: _____

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: _____

AFTER CARE GROUP: (if not applicable write N/A) _____

I will attend aftercare: Day of the Week: _____ Time: _____ Counselor: _____

12 STEP AND/OR OTHER SUPPORT NETWORK: I plan to attend the following weekly meetings:

Day	Location	Time	Times per Week

SPONSOR, MENTOR, SPIRITUAL ADIVISOR OR OTHER SUPPORT PERSON:

Name of Support Person: _____

I WILL MEET WITH HIM/HER: □ Daily □ Weekly □ Monthly □ Other: _____

Description of this commitment:

_____

_____

_____

SUPPORT GROUP COMMITMENTS (Community or Other Volunteer Services-Hospitals & Institutions, Coffee Maker, Religious/Spiritual):

Describe this commitment:

_____

_____

_____

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:

_____

_____

_____

RELAPSE PREVENTION AND WARNING SIGNS: (isolation, missed meetings, missed medications, failure, success, anxiety, anger, depression,-people, places or things that jeopardize my recovery)

My Relapse 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):

_____
_____
_____

PEOPLE I WILL CALL IF I FEEL LIKE USING OR BEHAVING IN WAYS THAT JEOPARDIZE MYSELF OR OTHERS:

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: _____

Client Completes this Section with the Counselor / Therapist

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 of Challenges / Barriers: INCLUDE RELAPSE TRIGGERS AND CLIENT SUPPORT PLAN (i.e., organizations, individuals)
1) Alcohol and Drug Use **2)** Medical **3)** Psychological / Emotional Health **4)**Employment & Support **5)** Legal **6)** Family & Social Skills **7)** Spirituality
***Stage of Change:**
A.) Pre-Contemplation **B.)** Contemplation **C.)** Preparation **D.)** Action **E.)** Maintenance **R.)** Relapse

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** ☐ **NO**
Providers 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 94244-2430
Oral Requests by Telephone: 1-800-952-5253 TDD – 1-800-952-8349

Counselor/Therapist Summary of the Treatment Episode:
Prognosis - Circle One: Excellent Good Fair Poor Guarded Unstable

☐ **Yes, Client Received Copy** ☐ **If no, must explain why:**

****Print Client Name**	****Signature**	****Date**
****Print Counselor/Therapist Name**	****Signature**	****Date**

****COMPLETE SIGNATURES REQUIRE LEGIBLY PRINTED NAME, SIGNATURE & DATE.** Original-File/Copy-Client

CCR Section 51341.1 (h) (6) (A) of Title 22 Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis.