

## DISCHARGE SUMMARY

The provider shall complete a Discharge Summary within 30 calendar days of the last face to face treatment contact for any beneficiary with whom the provider lost contact.

Client Name:		Client ID#:	Discharge Date:	Admit Date:	Date of Last Face to Face:
<b>Prognosis - Circle One:</b>					
<b>Excellent</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>	<b>Guarded</b>	<b>Unstable</b>
<b>Discharge Status – Check Appropriate Box(s)</b>					
<input type="checkbox"/> Successful	1.Treatment Plans/Goals Reached and Discharged with a Planned Exit				
<input type="checkbox"/> Satisfactory	2.Left with Satisfactory Progress & plans/goals partially met but without a Planned exit				
<input type="checkbox"/> Unsatisfactory	3.Discharged with poor progress in complying, poor achievement of treatment plans/goals.				
<input type="checkbox"/> Transferred	4.Transferred or referred to another program, moved, other level of SUD/MH care, i.e., medical needs.				
<input type="checkbox"/> Terminated	5.Termination of services due to repeated non-compliance (i.e., violations, threats of violence, under the influence on program premises)				
<b>Instructions:</b> The counselor/therapist Narrative Summary of the Treatment Episode includes presenting problem, treatment provided and final outcome. The narrative summary <b>must</b> include a reference to the following applicable areas: Current Drug Usage; Legal Issues and/or Criminal Activity; Vocational/Educational Achievements; Living Situation and Referrals.					
<b>Counselor/Therapist Summary of the Treatment Episode and Reason for Discharge:</b>					
<b>FAIR HEARING RIGHTS</b>					
<p><b>Was the client advised</b> of their Title 22 Sec 51341.1(p) Fair Hearing Rights if the discharge was involuntary?    <input type="checkbox"/> <b>YES</b>    <input type="checkbox"/> <b>NO</b></p> <p>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 related to their loss of eligibility or reduction of benefits, pursuant to Section 50951.</p> <p><b>To request a hearing contact:</b>            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</p>					
<b>**Print Counselor/Therapist Name</b>		<b>**Signature</b>		<b>**Date</b>	
<b>Client Initial:</b> _____ <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>Not Available</b> You have my permission to contact me during the next 12 months as a follow-up to my treatment.					

If the client is unavailable to sign this document the counselor must document efforts to contact the person.

**\*\*COMPLETE SIGNATURE REQUIRES LEGIBLY PRINTED NAME, SIGNATURE & DATE.**

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