**Alameda County Behavioral Health Care Services (ACBHCS)**

**Short-Term Residential Therapeutic Program (STRTP)**

**TRANSITION DETERMINATION PLAN**

**Client’s Name: Client’s Pronouns:**

**Case #: STRTP Name:**

**Date of Admission: Anticipated Transition Date:**

**Transition Determination Plan to be completed prior to child or youth’s discharge from the STRTP.**

**1. REASON FOR ADMISSION:** *Describe events in sequence leading to admission to your program. Describe primary need upon admission.*

**2. REASON FOR DISCHARGE FROM STRTP PLACEMENT:** *Choose most appropriate reason for transition. If selecting Other or Alternate STRTP/Residential Setting, provide explanation for reason for transition.*

☐ Higher level of care ☐ Lower level of care ☐ Client did not return/AWOL

☐ Alternate STRTP/Residential Setting ☐ Other *Explain*:

**3. LIVING PLACEMENT UPON DISCHARGE FROM STRTP:** *Choose most appropriate placement.* *If other provide explanation of living placement*.

☐ Biological Family ☐ Extended Family Member

☐ Non-Related Extended Family Member ☐ Resource Family

☐ Foster Family Agency ☐ Extended Foster Care/Transitional Housing Program

☐ Alternate STRTP ☐ Other *Explain*:

Name of caregiver and relationship to youth:

**4. COURSE OF TREATMENT DURING THE CHILD’S ADMISSION:** *Include mental health treatment interventions and the child or youth’s response. Include the child’s transition plan goals and child’s progress toward those goals*.

**5. MENTAL HEALTH DIAGNOSIS AND FOLLOW UP REQUIRED:**

a. Current Diagnosis: *List all diagnoses in order of priority.*

b. Symptoms related to diagnosis and follow up required:

c. Goals and expected outcomes for follow up treatment:

**6. RECOMMENDATIONS REGARDING TREATMENT THAT ARE RELEVENT TO THE CHILD’S CARE:** *Review with child or youth prior to transition. Use child or youth’s own language when applicable.*

a. Resiliency Strategies:

• Preferred activities or hobbies

• Soothing or calming techniques

• Identified sources of support (person, place, object)

• Caregiving strategies that promote resiliency

• Other

b. Triggers: Include social, emotional or environmental factors that may decrease the child or youth’s ability to be successful in next placement.

c. Other: Any other pertinent information which will enhance the child or youth’s successful transition.

**7. SUBSTANCE USE TREATMENT RECOMMENDATIONS:**

☐ Not Applicable ☐ Yes *Explain:*

**8. MEDICAL INFORMATION**:

a. *Medical and Dental Services Received While Residing in the STRTP*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Service | Date | Follow-up Required (yes/no) | Next Appointment Date | Next Appointment Time | Upcoming Due Dates (if no appt. scheduled) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

*b. Current Medications (Non-Mental Health)*

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |

c. *Psychotropic Medications - Attach documentation from prescribing physician, such as JV220, for potential and reported side effects of medication.*

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |

d. *Allergies and Adverse Medication Reactions*

**9. EDUCATIONAL INFORMATION:** *Include grade, grade level functioning, educational needs, education plans (for example IEP or 504 plan) and follow up required.*

a. Current grade:

b. Educational strengths:

c. Educational needs:

d. Educational Plans (i.e. Individualized Education Plan, 504 Plan, other):

e. Date the school was notified of discharge from the STRTP:

**10. REFERRAL(S):** ☐ Wraparound ☐ TBS ☐ School-Based Therapy

☐ Outpatient Mental Health Clinic ☐ Substance Use Treatment ☐ Other *Explain*:

Referral Contact Information:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Service | Program Name | Program Contact Name | Program Contact Phone Number | Appointment Date (if applicable) |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

☐ Client or caregiver declined referral(s)

**Explained in client’s primary language of:**

No ☐ (if no, document reason):

**Explained in guardian’s primary language of**:

No ☐ (if no, document reason):

**Language Assistance Services offered to client/guardian:**

Yes ☐ No ☐ (if no, document reason):

**Was a referral made to Language Assistance Services?**

Yes ☐ No ☐ (if no, document reason):

**Client offered a copy of the Transition Determination Plan:**

Yes ☐ No ☐ (if no, document reason):

**Copy of Transition Determination Plan offered to:** (Check the following as applicable. Copy shall be made available to at least one of the following.)

Parent ☐ Conservator ☐ Guardian ☐ Other ☐ If other, relationship:

**Copy of Transition Determination Plan offered to:** (Copy shall be made available to one of the following.)

Placing Agency Representative: ☐ CWS PSW ☐ Juvenile Probation Officer Placing Agency

Representative Contact Information: Name Phone Number

Date Placing Agency Representative notified of transition from the STRTP:

**SIGNATURES**

**Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_**

Refused to sign ☐ Explanation:

**Parent/Guardian Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_**

**Conservator Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_**

**Placing Agency Representative Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_**

**Other Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_**

**Signature of Staff Completing Transition Determination Plan:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_**

**Printed Name:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff ID#:\_\_\_\_\_**