Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

CHILD/ADOLESCENT DISCHARGE/TRANSITION PLAN

Enrollee Name _____ Medicaid Number # _____

Date the Child and Family Team met to develop this discharge/transition plan: _____

This document must be submitted with the completed Treatment Authorization Request (TAR), the required Person Centered Plan (PCP) and any other supporting documentation justifying the request for authorization and reauthorization of Intensive Alternative Family Treatment (IAFT), Residential Level III and Psychiatric Residential Treatment Facility (PRTF).

I. The recipient's expected discharge date from the following service is:

- ☐ IAFT — Expected Discharge Date: (mm/dd/yy) _____
- ☐ Residential Level III — Expected Discharge Date: (mm/dd/yy) _____
- ☐ PRTF — Expected Discharge Date: (mm/dd/yy) _____

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.

	Date (mm/dd/yy)	Provider:
☐ Outpatient Individual Therapy	_____	_____
☐ Outpatient Family Therapy	_____	_____
☐ Outpatient Group Therapy	_____	_____
☐ Medication Management	_____	_____
☐ Respite	_____	_____
☐ Intensive In-Home	_____	_____
☐ Multisystemic Therapy	_____	_____
☐ Substance Abuse Intensive	_____	_____
☐ Outpatient Day Treatment	_____	_____
☐ Therapeutic Foster Care	_____	_____
☐ PRTF	_____	_____
☐ Level III	_____	_____
☐ IAFT	_____	_____
☐ Other_____	_____	_____

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 of Support _____ Date: _____

Name of Support _____ _____ Date: _____

Consumer Name_____ Medicaid Number # _____

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)
- ☐ MCO/Care Coordination
- ☐ Residential Provider
- ☐ MH/SA Provider
- ☐ School (all those involved)

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	Responsible Party	Implementation Date

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:

Consumer Name_____ Medicaid Number # _____

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 (date mm/dd/yy) _____ in order to follow-up on the discharge/transition plan and address potential barriers.

X. Medical Information

a. Prevention Medical Appointment (dental) _____ (date mm/dd/yy)

b. Primary Care Appointment (physical) _____ (date mm/dd/yy)

c. Involved with CCNC Nurse Care Manager ☐ Yes or ☐ No

Consumer Name_____ Medicaid Number # _____

XI. Required Signatures

Recipient _____Date _____
mm/dd/yy

Legally Responsible Person _____Date _____
mm/dd/yy

Qualified Professional_____ Date _____
mm/dd/yy

(Person responsible for the PCP)

To Be Completed by Care Coordinator

☐ I agree with the Child and Family Team recommendation.

☐ I agree with the Child and Family Team recommendation with the following additional recommendations

☐ I do not agree with the Child and Family Team recommendation.

(*Please note signature below is required regardless of agreement with recommendation.)

MCO Care Coordinator_____ Date _____
mm/dd/yy

If "I do not agree" was checked, please explain concerns: