Mayview Regional Service Area Plan Project
State Hospital Discharge Community Support Plan*

IDENTIFYING DATA		**MEETING DATE:**	
Individual's Name	Date of Birth	Age	Social Security Number
Marital Status	Race/Sex		
SCU Number	Admission Date		Discharge Date

Role/Position	**Signature** **(I agree to the tasks assigned to me and I am committed fulfilling my responsibilities)**	**Print Name**	**Phone Number**	**Email Address**
Facilitator				
Recorder				
Advocate				
PSAN				
Allegheny County				
Medical Services Director				
CTT Liaison				
Social Worker				
SCU Liaison				
Psychiatrist				
Psych Aide				
Consumer				
AT WPIC				
Consumer Mtg. 1,2, 3				
AHCI-Facilitator Mtg. 1,2, 3				
Advocate				

*This form was developed by The Pennsylvania Office of Mental Health & Substance Abuse Services and adapted by the Mayview Regional Service Area Planning Project 2/10/06

Mtg. 1,2, 3				
MCO Mtg. 1				
Advocate, TSH Mtg. 1, 2, 3				
Clinical Nurse Mtg. 1				
ACHI Recorder Mtg. 1				
Allegheny County Mtg. 1, 2				
Psychiatrist, TSH Mtg. 1,2, 3				
Provider Mtg. 1, 2, 3				
Community Integration Specialist Mtg. 1				
Social Worker, TSH Mtg. 1, 3				
Recorder, AHCI Mtg. 2, 3				

County person is moving to:

Who is responsible and accountable for supervision and oversight of the Community Support Plan?

Name: _____ Title: _____

Agency: _____ Phone #: _____

ASSESSMENT STAGE:

1. CONSUMER ASSESSMENT SUMMARY
Strengths
Interests/Likes
Consumer's Dislikes

2. FAMILY ASSESSMENT SUMMARY
Strengths
Interests/Likes
Consumer's Dislikes

3. Clinical Assessment / Worksheet
Consumer Strengths: **Consumer Interests/Likes** **Consumer Dislikes**
Consumer Interests /Likes
Consumer Dislikes
Consumer Psychiatric and Behavioral Conditions to consider
Consumer Physical Conditions to consider

INFORMATION GATHERING STAGE:

TOPIC AREA #1: RECOVERY SERVICES AND SUPPORTS IN THE COMMUNITY

TOPIC AREA #2: LIVING ARRANGEMENTS / HOUSING

TOPIC AREA #3: INSURANCE / BENEFITS / ENTITLEMENT

TOPIC AREA #4: PHYSICAL HEALTH CARE

TOPIC AREA #5: MENTAL HEALTH CARE

Follow-up items / person responsible / due date:

OPTIONS STAGE:

TOPIC AREA #1: RECOVERY SERVICES AND SUPPORTS IN THE COMMUNITY

TOPIC AREA #2: LIVING ARRANGEMENTS

TOPIC AREA #3: INSURANCE / BENEFITS / ENTITLEMENT

TOPIC AREA #4: PHYSICAL HEALTH CARE

TOPIC AREA #5: MENTAL HEALTH CARE

Follow-up items / person responsible / due date:

TRANSITION STAGE:

TOPIC AREA #1: RECOVERY SERVICES AND SUPPORTS IN THE COMMUNITY

TOPIC AREA #2: LIVING ARRANGEMENTS

TOPIC AREA #3: INSURANCE / BENEFITS / ENTITLEMENT

TOPIC AREA #4: PHYSICAL HEALTH CARE

TOPIC AREA #5: MENTAL HEALTH CARE

Follow-up items / person responsible / due date:

FINAL PLAN:

INSURANCE / BENEFITS / ENTITLEMENTS					
Insurance/ Benefits/ Entitlement: **Rent will be monthly.**	SSI? ☐	SSDI? ☒	Amount	#	
	Medicaid: _____		Medicare: X		
	Private Insurance: _____				
	Medications Paid By:				
	Food Stamps: _____ Section 8 _____Other Benefits: _____ Waiver: _____				

Applications Filed & Follow-up Needed	Application	Follow-up action	Responsible Person
1) Social Security 2) 3)	Change of address	Complete on day of discharge	

Income	Amount $ every ___ Source:	
Representative/ Guardian/Payee	Name	
	Address	
	Phone	Relationship Payee

PHYSICAL HEALTH CARE (Upon Discharge Attach Medical History and Most Recent Blood Work and Labs)		
Physical Health treatment Needed after Discharge	1. **Type of Physician**:	**Name:**
	Address/Location:	
	Phone:	
	2. **Type of Physician**:	**Name:**
	Address/Location:	
	Phone:	
	3. **Type of Physician**:	**Name:**
	Address/Location:	
	Phone:	
	Diagnoses:	
	1.	

	2.	
	3.	
	4.	
	5.	
	6.	
	Medications & Dosage (List or attach)	**Supply (# of days)**
	Who will fill new supply?	

Describe any special needs regarding physical health needs including medication administration, frequency of appointments, frequency of monitoring health concerns, etc.

Multi-Agency Special Needs	**Note coordination of care, accommodations needed, assistive devices, etc.**			
☐ Aging ☐ Blind ☐ Criminal Justice ☐ Deaf ☐ Hard of Hearing ☐ Mental Retardation / Develop Disability	☐ Physical Disability ☐ Traumatic Brain Injury ☐ Non-English Language ☐ Other	**Describe in detail what the consumer needs.**		
		List the following:		
		Agency	**Specific Need**	**Contact/#**

Describe any additional needs or information regarding the above:

LIVING			
Type of	☐ Own home/Apt	☐ Shared home/Apt	☐ Single room

Residence ☐ Permanent Transitional	☐ Personal Care Home	☐ Community Residential Rehab	☐ Fairweather Lodge
	☒ Long Term Structured Residence	☐ Supportive Housing	
	☐ Other		
	Total number of persons in shared living situation:		
Level of Independence	☐ Living independent	☐ Family Setting	☐ Living Dependently
	☐ Supervised Setting	☒ Restrictive Setting	☐ Living semi-independently
Address:			
Agency: (If applicable)	Name of Agency		Phone #
Agency Contact:			

MENTAL HEALTH CARE			
Does the Consumer have a Psychiatrist in the community? (name)			
Phone	**Address**		
What is the Current Diagnosis (Axis I-V): I:			
Community Treatment Needed	**Type**	**Frequency**	**Provider/Contact Name/ #**
	☒ Outpatient/Group Content:		
	☐ Outpatient/Individual Content:		
	☐ Drug & Alcohol Content:		
	☐ Co-Occurring Services Content:		
	☐ Other: Content:		
	☐ Other: Content:		
	☐ Other: Content:		
Clinical Treatment Needed After Discharge	**Psychiatrist (name)**		
	Phone	**Address**	
	Diagnosis (Axis I-V):		
	Discharge Medications & Dosage (List or attach)		**Supply (# of days)**

	Who will fill new supply:	
Describe any special needs regarding medication administration including medication drops, consequences of changing or titrating medications, recommendations on titration, etc.		

CASE MANAGEMENT/CTT SERVICES				
While Consumer is Inpatient:				
Intensive Case Management ☐	Blended Case Management ☐	Resource Coordination ☐	Administrative Case Management ☐	Community ☒ Treatment Team
Provider	**Contact Name and Phone Number**		**Frequency of Contact**	
After Consumer is Discharged:				
Intensive Case Management ☐	Blended Case Management ☐	Resource Coordination ☐	Administrative Case Management ☐	Community ☒ Treatment Team
Provider	**Contact Name and Phone Number**		**Frequency of Contact**	

RECOVERY SERVICES AND SUPPORTS			
List the friends and family members the consumer wants to keep in contact with in the community	Name of Person	Relationship	How often?

List community peer organizations, drop-ins, or mentorship programs the consumer wants to participate	**List the organization, contact, and number of hours he/she wants to be involved** (Some ideas include Compeer, Warmline, Helpline, Drop-In Center, AA, NA, Support Group, Peer to Peer, Consumer Movement (PMHCA, NAMI, PSAN, CSP, etc):		
	Name of Organization	**Contact**	**How often?**

List meaningful activity (rehabilitative, educational, and work activities) consumer wants to participate in during the days.	**List the activity, days and number of hours he/she wants to be involved** (Some ideas include Mobile PRS, Site-Based PRS, Clubhouse, Peer Mentor, Supported Employment, Competitive Employment, Volunteer, Hobbies, GED, Continuing Ed, Enrichment like pottery and gardening):		
	Activity	**Days per week**	**# hours each day**

List what Leisure/Fun Activities the consumer wants to do during the evenings and weekends	**List the activity, days and number of hours he/she wants to be involved (**Some ideas include hiking, swimming, camping, movies, eating out, going to baseball games, bowling, watching sports on TV, sewing, book club, traveling, etc):		
	Activity	**Days**	**Number of Hours Per Day**

Spiritual Supports including church, temple, groups, gatherings, tribes, etc.	**List where, with whom, and how often the consumer wants to practice his/her spirituality.**		
	Where	**With Who**	**Days/Hours Per Day**

Cultural Supports including own heritage or another	**List where, with whom, and how often the consumer wants to practice and/or explore culture.**		
	Where	**With Who**	**Days/Hours Per Day**

RISK/SUCCESS FACTORS	*Note based on individual's history what has occurred to put the person at risk for rehospitalization and what has helped the person remain in successful community placement*		
Risks			
☐ Suicide Attempts/Ideation	☐ Medication Issues	☒ Anger/Aggression	☒ Substance Abuse
☐ Self-Directed Travel/movement	☒ History of hallucinations.	☐	☐
Describe what helps the consumer stay out of the hospital.			
Describe what helps the consumer remain psychiatrically stable.			
Describe what type of help and from who the consumer needs help when he/she is feeling unsafe or at risk**.**			
Describe any other information relative to the above.			

ADVANCE DIRECTIVE OR CRISIS PLAN (Attach all relevant documentation upon discharge)				
Physical Health	Information provided	☐	Additional Info or Assistance Requested	☐
Mental Health	Information provided	☐	Additional Info or Assistance Requested	☐
Describe in detail what the consumer needs to help him/her leave the hospital with an agreed upon crisis plan and/or an advanced directive.				

Individual Crisis Plan