CONTRA COSTA
ALCOHOL & OTHER
DRUGS SERVICES
A Program of Behavioral Health Services

Discharge Plan

NAME / MRN

Program Name:		Today's Date:
Facility ID:	Program ID:	PROCEDURE CODE: ☒ 129 Discharge Planning

This is my personalized Discharge Plan to support my ongoing recovery. My Discharge Plan was completed with my counselor within the last thirty (30) calendar days to the completion of my treatment in this facility.

My Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unstable

Date of Last Completed ASAM:	Admission Date:	Discharge Date:	Type of Discharge: ☐ Voluntary ☐ Involuntary

☐ **Interpreter Name of Interpreter:**
Language service provided in other than English: ☐ **Spanish** ☐ **Other**

Narrative Summary of the Course of Treatment Episode

Based on ASAM completed on

☐ **Dimension 1:** Acute Intoxication and/or Withdrawal Potential
☐ **Dimension 2:** Biomedical Conditions and Complications
☐ **Dimension 3:** Emotional, Behavioral, or Cognitive Conditions and Complications
☐ **Dimension 4:** Readiness to Change
☐ **Dimension 5:** Relapse, Continued Use, or Continued Problem Potential
☐ **Dimension 6:** Recovery/Living Environment

Indicate the justification for continuation of Substance Use Disorder treatment services in NARRATIVE format
Must include narrative for any ASAM Dimensions marked above

NAME / MRN

Description of relapse triggers and plan to avoid relapse when confronted with each trigger:	
MY RELAPSE TRIGGERS ARE	**MY RELAPSE PLAN IS**

MY SUPPORT PLAN

Mark as Appropriate:

☐ Linked to Medical Care
☐ Linked to Mental Health Services
☐ Aftercare Group Location: _____

☐ Linked to Recovery Support Specialist Name of RSS: _____
☐ Linked to Sponsor
☐ Relapse Prevention Group Location: _____

☐ 12 Step Group Location: _____ Day:_____ Time:_____
☐ Linked to Mentor
☐ Linked to Spiritual Advisor
☐ Linked to Faith Based Support Location: _____
☐ Social Activities
☐ Community Volunteer Services
☐ Other Name of Program:_____

MEDICATION	DOSE/FREQUENCY	REASON

Based on my most recent treatment experience and to continue my recovery journey, I agree to the following:

I WILL MEET WITH SPONSOR, MENTOR, SPIRITUAL ADVISOR, RECOVERY SUPPORT SPECIALIST, OR OTHER SUPPORT:

I will meet with my Support Person: ☐ Daily ☐ Weekly ☐ Monthly

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

☐ If I need help, I will call my Recovery Support Specialist using the number provided today

Name of Person	Telephone Number

NAME / MRN

I WILL ATTEND THE FOLLOWING ACTIVITY COMMITMENT: (COMMUNITY VOLUNTEER ACTIVITY, COFFEE MAKER, RELIGIOUS/SPIRITUAL, OUTSIDE GROUPS, SOCIAL ACTIVITIES):

Discharge Status

Reasons for Discharge or Referral:

☐ Completed treatment goals/plan at this level of care

☐ Client leaving prior to completing treatment goals/plan with satisfactory progress

☐ Client leaving prior to completing treatment goals/plan with unsatisfactory progress

☐ Designated SUD level of care not available at this time

☐ Discharged into more appropriate Behavioral Health system of care

☐ Discharged by agency for due cause (e.g. non-compliance with agency rules)

☐ Does not meet SUD Medical Necessity for this level of care ☐ Death ☐ Incarceration

☐ Other: _____

If transitioning to another Level of Care, please include the following:

Name of Program:_____

Appointment Date: _____ Appointment Time: _____

Recommendation for Follow-up (Medical, Dental, SUD Level of Care, Mental Health, Legal, Family, etc.):

AOD Counselor/LPHA Printed Name:	**AOD Counselor/LPHA Signature:**	**Date:**

I was advised of the 42 CFR, 438.10 Fair Hearing Rights if the discharge was due to loss of Medi-Cal benefits? ☐ Yes ☐ No

I was provided a copy of the Fair Hearing Rights: ☐ Yes ☐ No

☐ **Notice of Adverse Benefit Determination Issued**

Beneficiary Name:	**Beneficiary Signature:**	**Date:**

If no signature, indicate reason:

Has a copy of the Discharge Plan been provided to the Beneficiary? ☐ Yes ☐ No Explain:

This program has my permission to contact me during the next 12 months from today's date as a follow-up to my treatment and recovery. ☐ Yes ☐ No