Mental Health Institute Discharge Plan

Person's Name	Institute Number	☐ Voluntary ☐ Involuntary	☐ Mental Health ☐ Substance Abuse

Reason for Discharge:

Discharge Plan

Check plan actions required and complete including name of any provider.

Community Living Plan	Plan Action Required	Employee Responsible	Time Fame	In Place
☐ Living arrangment				☐ Yes ☐ No
☐ Nutrition				☐ Yes ☐ No
☐ Transportation				☐ Yes ☐ No
☐ Medical care other than psychiatric				☐ Yes ☐ No
☐ Social supports and activities				☐ Yes ☐ No
☐ Education and training				☐ Yes ☐ No
☐ Other (specify):				☐ Yes ☐ No

Continued Treatment Plan	Plan Action Required	Employee Responsible	Time Fame	In Place
☐ Supervised residential living				☐ Yes ☐ No
☐ Community living support services				☐ Yes ☐ No
☐ Outpatient therapy				☐ Yes ☐ No
☐ Medication management				☐ Yes ☐ No
☐ Continued inpatient treatment				☐ Yes ☐ No
☐ Other (specify):				☐ Yes ☐ No

Funding for Required Supports

Person:

☐ Does not require assistance with funding ☐ Requires assistance through CPC process ☐ Requires other financial assistance

Describe:

Available community support persons:

Crisis plan:

This plan was developed with my input and assistance. I agree to its implementation and I am responsible to:

My intent is to follow through with those parts of the plan for which I am responsible.

Person's Signature	Date

Responsibilities of the Mental Health Institute following discharge:

Responsible Employee's Signature	Date