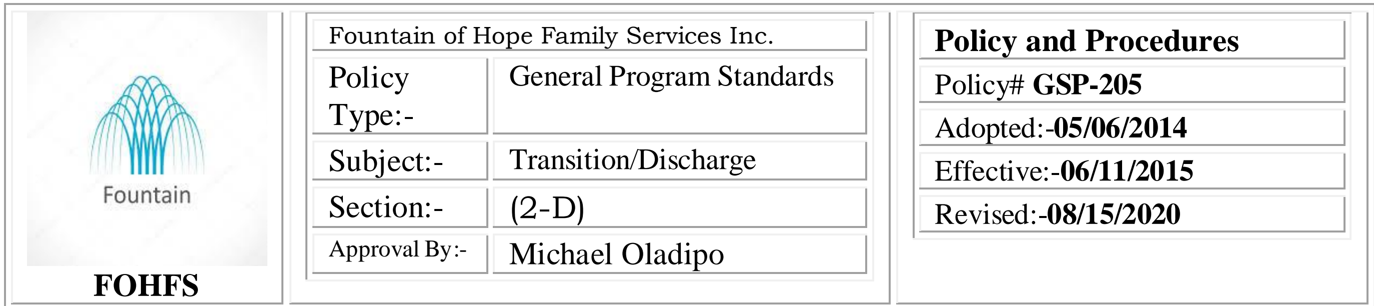

FOHFS	Fountain of Hope Family Services Inc.		Policy and Procedures
	Policy Type:-	General Program Standards	Policy# **GSP-205**
	Subject:-	Transition/Discharge	Adopted:-**05/06/2014**
	Section:-	(2-D)	Effective:-**06/11/2015**
	Approval By:-	Michael Oladipo	Revised:-**08/15/2020**

Transition/Discharge

1. Written transition and discharge criteria are established and used. Transition/Discharge Summary forms includes a discharge criteria and expected needs on discharge and support systems needed to maintain current level of functioning at discharge to ensure a successful transition/discharge for the Client. This form is signed by the Clinician during intake and again when the Client is discharged from **FOHFS Agency** to ensure the established criteria are used.
2. **FOHFS Agency follows its procedures for:**
   a. **Referrals:** Referrals are made by the Clinician to address identified needs that are not being addressed by the services **FOHFS Agency** provides.
   b. **Transitions to other services**: **FOHFS Agency** works with other agencies to provide a variety of serves to meet the person's served needs.
   c. **Discharge**: **FOHFS Agency** will discharge persons served who are receiving talk therapy form another mental health Agency to prevent duplication of services.
3. **FOHFS Agency** begins to address the discharge/transition process during the intake to ensure the Client is as prepared as possible for the discharge/transition process.
4. As appropriate, Clients have options to move to community integrated settings. **FOHFS Agency** refers Clients to self-help groups within their community to encourage person's served to develop a support system within their communities.

5.
   a. A written Transition/Discharge Summary is developed with the input and participations of the Client, the family/legal guardian, when applicable or permitted by the Client, a legally authorized representative, when appropriate, personnel, the referral source when appropriate and permitted by the Client, and other community services, when appropriate and permitted by the Client.
   b. The Transition/Discharge Summary identified the person's current progress toward his or her own recovery or move toward well-being and gains

achieved during program participation.

c. The Transition/Discharge Summary identifies support systems needed to maintain current level of functioning at discharge to ensure a successful transition/discharge for the Client.
d. Does not apply. **FOHFS Agency** does not assist with medications.
e. Clinicians are responsible for identifying and documenting on the Transition/Discharge Summary any referrals made including contact information, telephone number, location, hours, and days of services when applicable.
f. The Transition/Discharge Summary includes: I understand that should my symptoms recur or if I need additional services, I may contact the **FOHFS Agency** office for readmission and/or referral to appropriate outside services. With a place to sign to indicate the person's served understanding. Persons served are also provided with a brochure that includes contact information.

6. Strengths, needs, abilities, and preferences are documented on the Transition/Discharge Summary.
7. Individuals who participate in the development of the transition plan are provided with a copy of the Transition/Discharge Summary upon request.
8. The primary provider is responsible for maintaining the continuity and coordination of needed services, to determine with the Client whether further services are needed, and to offer or refer to needed services when possible.
9. When an unplanned discharge occurs the Clinician will determine with the Client whether further services are needed, and will offer or refer to needed services when possible.
10. When a person is discharged from receiving services from **FOHFS Agency**, the Management Team is responsible to ensure linkage to appropriate care within **<u>72</u>** hours post discharge.
11. A written Transition/Discharge Summary is prepared by the Clinician to ensure that the Client has documented treatment episodes and results.
    a. Transition/Discharge Summary includes the date of admission.
    b. Transition/Discharge Summary describes the services provided.
    c. Transition/Discharge Summary identifies the presenting problem on admission.
    d. Transition/Discharge Summary includes the person's served progress toward reaching goals and objectives.
    e. Transition/Discharge Summary includes the reason for discharge.
    f. Level of functioning at discharge is identified by the Clinician on the Transition/Discharge Summary form.
    g. The Clinician is responsible for listing recommendations for services or support on the Transition/Discharge Summary form.
    h. The Transition/Discharge Summary form includes the date of discharge

from the program.

□ Follow-Up of a Discharged Individual

Follow-up services will be considered for any individual in a **FOHFS Agency** program.

When an individual is discharged from a **FOHFS Agency** program, the counselor will consider the need for follow-up services on an individual basis. This is done through the treatment team's consideration of that individual's specific circumstances and a determination of whether follow-up services are warranted. Any recommendations for follow-up services are documented in the discharge summary. Documentation of follow-up contacts is maintained in the individual's case record.