

North Country Community Mental Health

Additional Consultations Needed: Yes No If Yes, which discipline/s: _____

Restrictions: _____

Discharge Planning: (What are the conditions needed for discharge? Reduction in symptoms, return to highest GAF/GAS score, transfer to community supports, etc.) _____

Is it likely that the person will be ready for discharge from services by CMH:

- Within the next six months Within the next twelve months Within the next two years
 Within the next five years In more than five years

What are the conditions for transition to another level of care, if not ready for discharge? _____

What are the conditions needed for continued success after discharge? _____

Person-Centered Planning Process:

- I understand the role of family and friends, the community's roles, public agencies roles and the role of the community mental health center.
- I was actively involved in the development of this plan of service, through the person-centered planning process.
- I was able to choose the people involved in my planning meeting.
- The planning meeting was held at a time and place convenient to me.
- I have received a copy of the Recipient Rights book, the privacy notice and the community mental health member handbook. *(Please read and refer to these brochures as they contain very important information.)* Any type of physical or verbal abuse, or sexual contact by staff is not permitted. Report any such incidents to the rights officer immediately.
- I have been advised of my right to revise the plan and I understand that we will review the plan as often as necessary, but at least every _____ months.

Conflict Resolution:

- I am aware that I can contact my CMH worker _____ at _____ or their supervisor _____ at _____ to help resolve any concerns that I have regarding my treatment.
- I have received the local grievance and appeal form and have been advised of my rights to appeal, grievance, fair hearing and/or alternative dispute resolution.
- I can expect that there will be no retaliation or harassment resulting from the good faith filing of one or more recipient rights complaints or grievance and appeals. The recipient rights officer for North Country CMH is Karen Oliverius and can be reached at 1-800-281-0481
- If I have questions about services or supports I can contact member services. The member services designee is _____ and can be reached at _____

Other:

- I am knowledgeable of, and concur with, the behavior modification plan as developed by the person-centered planning team and grant my consent for the use of restrictive techniques as written and identified. I further understand that the Behavior Management Committee will regularly review these techniques. Not applicable
- I have read these statements, have been given the information described above, and have had my questions answered. I know that if I have further questions I may ask at any time for additional information or clarification.
_____ (Initial)

Current Address: _____

Current Phone: _____ **Primary Care Physician:** _____

Name:	ID #	Date
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**Plan of Service
Discharge Planning, Agreements and Consents**