Model Care Coordination Plan[1]

Patient's Name: _____
Medical Record Number: _____
Date of discharge: _____

Model Care Coordination Plan: Patient Rights and Instructions

As required by state law[2], as the patient you must be provided a scheduled follow-up appointment and referral for further care before discharge from this facility. The facility is not permitted to involuntarily hold you longer than otherwise permitted solely because of the requirement to provide a follow-up appointment.

You are encouraged to accept a follow-up appointment but have the right to refuse. California law requires state-regulated health plans to provide timely access to care. This means that there are limits on how long you must wait to get health care appointments and telephone advice. If you have a problem getting timely access to care, you should call your health plan.

Discharge Disposition (choose one)[3]

☐ Unhoused

(Describe):_____

☐ Shelter with supportive services

(Describe):_____

☐ Home

☐ Home with family/supportive person(s)

☐ Facility (Name, address, and type)
(Describe):
_____
_____

Other
(Describe):
_____
_____

☐ Decline to state

(Describe):
_____
_____

Diagnosis:_____

Expected course of recovery:_____
_____
_____

[1] Welf. & Inst. Code §§ 5257.5, 5402.5(c)(2)
[2] Welf. & Inst. Code §§ 5152(c)(1), 5257.5(a), 5361(c)(2); see Welf. & Inst. Code § 5402.5(b)(2)
[3] Health & Safety Code 1262 and 1262.5

Recommended follow-up:_____

_____

Medications prescribed and side effects and dosage schedules *(a signed informed consent form for medications, if attached to this form, may satisfy this requirement)*:_____

_____

_____

Recommendations regarding treatment that are relevant to the patient's care:_____

_____

_____

Other information/instructions:_____

_____

Legal Status

Current Legal Status upon discharge: ☐ Voluntary ☐ LPS Conservatorship

A model care coordination plan is required for any individual who is being discharged from an Lanterman-Petris-Short (LPS) designated facility who has been detained under the LPS Act on a hold or conservatorship.

Please identify the type of legal status that applied to this individual prior to discharge (required):

Type of Involuntary Hold: _____ County where hold was placed: _____
Date when hold was placed: _____ Time (if applicable): _____ ☐ AM ☐ PM
Date the hold ended:_____ Time (if applicable): _____ ☐ AM ☐ PM

Type of Conservatorship: _____ County where conserved: _____
Date when conservatorship was established: Date when conservatorship was ended:
_____ _____

Referrals and Follow-Up Services

Referrals may include, but are not limited to, informing the person of available services, making appointments on the person's behalf, discussing the person's service needs with the agency or individual to which the person has been referred, appraising the outcome of referrals, and arranging for personal escort and transportation when necessary. Referral shall be considered complete when the agency or individual to whom the person has been referred accepts responsibility for providing the necessary services.

Select one option:

☐ The **discharging facility** has set up a follow-up behavioral health appointment for you. Based on the information provided regarding your insurance and the recommendations provided by your treatment team, you have been provided with the following appointment.

Provider Name:_____
Appointment Address (or location):_____
Appointment Date & Time:_____
Appointment Service Delivery *(Telehealth/In Person):*_____
Provider Contact:_____

Planned Means of Transportation to Appointment *(if known):*_____
Services to be provided:_____

Please let your provider know if you need any translation of information or need any transportation assistance to attend your follow up appointment. Your provider may talk to you about transportation resources that may be available to you.

Language Assistance Needed? ☐ Yes ☐ No | If yes, please describe: _____

Transportation Assistance Needed? ☐ Yes ☐ No | If yes, please describe:

Disability/other accommodations needed? ☐ Yes ☐ No | (If yes, please describe):

☐ Despite our best efforts, a follow-up behavioral health appointment was unable to be scheduled and would have delayed discharge. For follow up care please contact:

Contact Name/Organization:_____
Phone number:_____
Email (if applicable):_____
Address (if applicable):_____
Why the appointment was not able to be scheduled:_____

☐ Patient declined follow up appointment

Other Patient Referrals

Name/Agency:_____
Address:_____
Phone:_____
Comments:_____

Name/Agency:_____
Address:_____
Phone:_____
Comments:_____

Name/Agency:_____
Address:_____
Phone:_____
Comments:_____

Care Coordination Team Information

NOTE: Pursuant to state law[4], care coordination is a shared responsibility between, at minimum, the county, the facility, the individual receiving treatment, and the responsible health insurance plan, if the county is not the responsible party.

Care Coordination Team Information:
This care coordination plan should identify who will be on the care team and the roles of each entity to ensure continuity of services and care.

Discharging facility: _____
Role of the discharging facility: _____
Facility Care Team: _____
Contact Information: _____
Email: _____
Phone: _____
Address: _____

County in which person was placed on hold: _____
Role of the County: _____
County Care Coordination Contact Name/Title: _____
Contact Information: _____
Email: _____
Phone: _____
Address: _____

Responsible Health Plan:
Role of the Health Plan: _____
Contact Information: _____
Phone: _____
Address: _____

Post-Discharge Mental Health Provider(s): _____
Role of provider: _____
Psychiatrist: _____
Other treatment provider(s): _____
Contact Information: _____
Phone: _____
Address: _____
Coverage/Payer (name of insurance or Medi-Cal plan): _____
Coverage Type: ☐ Medi-Cal ☐ Medicare ☐ Commercial ☐ Self-Pay ☐ Other

Post-Discharge Substance Use Disorder Treatment Provider(s):
Role of SUD treatment provider: _____
Contact Information: _____
Phone: _____
Address: _____
Coverage/Payer (name of insurance or Medi-Cal plan): _____
Coverage Type: ☐ Medi-Cal ☐ Medicare ☐ Commercial ☐ Self-Pay ☐ Other

Primary Care Provider(s):
Role of primary care provider: _____
Contact Information: _____

[4] Welf. & Inst. Code §§ 5257.5, 5402.5(c)(2)

*Phone:*_____
*Address:*_____
*Coverage/Payer (name of insurance or Medi-Cal plan):*_____
Coverage Type: ☐ *Medi-Cal* ☐ *Medicare* ☐ *Commercial* ☐ *Self-Pay* ☐ *Other*

Comments: _____
_____
_____

(**NOTE:** If any item listed above is not completed, explain why in the comments area.)

Date:_____
Name of person preparing this aftercare plan:_____
Title of the person preparing this aftercare plan:_____
Contact information of the person preparing this aftercare plan:_____
_____

You have the right to designate someone to receive a copy of this plan on your behalf.

Patient's designation to receive a copy of this plan: ☐ Declines ☐ Designates the following person(s):

Name:_____
Designated Person Role (if applicable):_____
Phone:_____
Email:_____
Mailing Address:_____
City/State/Zip:_____