Vermont Psychiatric Care Hospital Procedure	
Discharge Planning	
Revised: X	Date: 04/07/14

1. The patient's assigned social worker will complete a Comprehensive Social Assessment by the time the treatment team meets to develop the Comprehensive Interdisciplinary Treatment Plan. This assessment will include a preliminary discharge plan focusing on the patient's strengths and needs and setting forth recommendations for aftercare. The preliminary discharge plan shall address, among other things, the patient's medical and psychiatric needs, financial resources, housing, employment, educational and vocational opportunities, family and social relationships, community supports, legal issues, and transportation needs.

2. Within seven (7) business days of a patient's admission to the Vermont Psychiatric Care Hospital (VPCH), the patient's treatment team shall prepare, in collaboration with the patient, a Comprehensive Interdisciplinary Treatment Plan setting forth specific assessments and interventions for that patient. Each Comprehensive Interdisciplinary Treatment Plan shall contain a Social Service Intervention which addresses goals related to discharge planning. The patient's treatment team shall prepare the Comprehensive Interdisciplinary Treatment Plan in collaboration with appropriate community agencies. With the patient's approval, the treatment team shall also encourage the patient's family members and/or significant others to assist in formulating the Comprehensive Interdisciplinary Treatment Plan.

3. Discharge planning is a process that continues throughout a person's hospitalization. Changes in the patient's condition and circumstances may require changes to the discharge plan. The discharge plan will be regularly and systematically reviewed by the patient, the social worker, the treatment team, and outpatient providers. The discharge plan shall be periodically updated to reflect the evolving needs and desires of the patient and the availability of resources in the community. The patient's progress and any changes in the aftercare plan will be noted in the weekly Social Services Aftercare & Discharge Planning Progress Note.

4. At the time of discharge, the Social Worker will complete an Aftercare Referral Form. This form provides specific information regarding the patient's living situation, source of income, medications, medical needs, appointments, conditions of release, and contact information. Upon discharge, the patient will be given a copy of this form and a copy will be sent to the Designated Agency or outpatient provider in order to ensure continuity of care, and a copy may be provided to a person designated by the patient. In addition, a list of home health agencies (HHA) or skilled nursing facilities (SNF) participating in the Medicare program and serving the patient's geographic area will be presented to those patients where services are indicated.

Approved by	**Signature**	**Date**
Frank Reed, Commissioner of DMH	Frank Reed	11/29/16