Home and Community Living Administration (HCLA)

Individualized Community Transition Planning Summary

This form is for inpatient settings when initiating the request for assessment, transition planning, and collaboration with Home and Community Services (HCS).

Client Demographic Information

Client's Full Legal Name	Date of Birth	Medical Record Number

Facility Name

Primary Social Worker's Name	Phone Number (with area code)	Date completed by inpatient staff

Client Clinical Summary

Please provide both ICD-10 codes (when available) and the name(s) of any diagnostic information listed below.

Primary Mental Health Diagnosis (Principal Diagnosis): Please list the diagnostic information (as found in the most recent treatment plan):

- Primary mental health diagnosis:
- Secondary mental health diagnosis(es):
- Primary medical diagnosis / comorbidities:

Community Services Engagement:

Was the client engaged in behavioral health services prior to current hospitalization? ☐ Yes ☐ No ☐ N/A

Please list any known supportive community services the client was engaged in prior to current hospitalization:

Has the client expressed interest in re-engaging in community-based behavioral health or supportive services upon Transition? ☐ Yes ☐ No ☐ N/A

If yes, please specify:

Medication and Medical Conditions Monitoring

In an inpatient setting, the client is:

- Taking **psychotropic medication** as directed and agreeable to treatment(s): ☐ Yes ☐ No ☐ N/A
- Taking **physical health medication** as directed and agreeable to treatment(s): ☐ Yes ☐ No ☐ N/A
- Requesting or needing **psychotropic PRN medications**: ☐ Yes ☐ No ☐ N/A
- Requesting or needing **physical health PRN medications**: ☐ Yes ☐ No ☐ N/A

Last medication review date:

Additional comments:

Risk Assessment and Legal Status for Transition Planning

Document the client's current and historic risk status for self-harm or harm to others.

History of suicide attempts? ..... ☐ Yes ☐ No ..... Last known date of attempt:

Provide relevant suicide history:

History of assault? ..... ☐ Yes ☐ No ..... Date of last occurrence(s):

Provide relevant assault history:

History of homicidal ideation? ..... ☐ Yes ☐ No ..... Date of last occurrence:

Provide relevant history of homicidal ideation or violent behavior:

If any of the following are applicable, please provide known details:

Is the client a Registered Sex Offender (RSO)? ☐ Yes ☐ No ……. RSO Level (if known):

Active warrants? ☐ Yes ☐ No ☐ Unknown

Active No Contact Orders? ☐ Yes ☐ No

Current commitment type: ☐ Voluntary ☐ Civil ☐ Forensic / Competency Restoration

Current Court Order expiration date:

DOC supervision? ☐ Yes ☐ No If yes, DOC contact:

Additional information:

Observable impulsivity risk: ☐ Low ☐ Moderate ☐ High ☐ N/A

Community Treatment Supports

☐ MCO / ASO ☐ Fee For Service (FFS) MCO / ASO Assignment:

Liaison's Name	Email Address

Suggested community treatments:

For Inpatient Behavioral Health and Habilitation Administration (BHHA) Clients Only

For inpatient Behavioral Health and Habilitation Administration clients only, please complete the following:

Is a Civil Discharge Review required? ☐ Yes ☐ No

Date completed (if pending, list date of referral):

Legal notification requirements:

☐ Prosecutor ☐ Law Enforcement ☐ End of Sentence Review Committee (ESRC)

☐ SFVF / PSRP ☐ Victim / Witness

Alleged Index Offense(s) (please include the alleged offense that led to current hospitalization if applicable):

Behavior Snapshot

Completed collaboratively between the inpatient setting and HCS: This section is to identify **historical and current behaviors** that the client is or has exhibited / experienced noting the status, frequency, and management status, along with known triggers and individualized interventions. For a more comprehensive list of behaviors, please reference the Instructions section.

Behavior	Current Status	Frequency	Management	Triggers / Intervention(s)
	☐ Current ☐ Historical Date of last occurrence:	☐ Daily ☐ Weekly ☐ Less than weekly Date of last occurrence:	☐ Active - Limited responsiveness to intervention ☐ Active - Responsive to intervention ☐ Stable / Managed with current treatment plan ☐ Resolved / Historical	
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Date completed:				

Instructions for Individualized Community Transition Planning Summary

This form should be included as a part of the client's referral packet provided to HCS by the inpatient setting with Pages 1 and 2 completed to support the assessment and transition planning process. The Behavior Snapshot will be completed collaboratively by HCS and the inpatient setting.

Client Demographic Information

Please provide the client's full legal name, date of birth, and medical records number.

Client Clinical Summary

Provide any known IDC-10 codes and the name(s) of any diagnoses provided. This assists the HCS case manager in creating an accurate assessment while streamlining access to potential additional support for the client upon transition.

Primary Mental Health Diagnosis (Principal Diagnosis): The primary or principal mental health diagnosis is the condition established after study to be chiefly responsible for the admission of the client to the inpatient facility or the reason the client is requiring or seeking care and/or treatment.

Community Services Engagement: This section is to identify any known behavioral health services that the client was engaged in prior to the current hospitalization, listing those services and identifying those services that the client has expressed interest in engaging in upon transition.

Medication and Medical Conditions Monitoring

Inpatient: Describe the extent to which the client is **compliant with both psychotropic and physical health medications** while inpatient. Some examples of non-compliance include refusal or compliance being achieved only because of actions a healthcare professional took. Indicate only "Yes", "No", or "N/A". Also, identify if the client is **requesting or needing both psychotropic and physical health medications.** Additional comments should be used for relevant information or details to assist with assessment.

Risk Assessment and Legal Status for Transition Planning

Risk Assessment & Legal Status for Transition Planning: Based upon clinical evaluation, document and explain the following:

- For each item, check "Yes" or "No" Additionally, provide details when prompted of any known history or information requested for suicidal ideation or behavior, assaultive behavior, or homicidal ideation / violent behavior for effective community transition, registered sex offender status/level, active warrants, active no contact orders, commitment type, current court order expiration date, and Department of Corrections (DOC) supervision.
- For purposes of understanding on this form, the definition of **impulsivity** is the tendency to act quickly without adequate forethought, resulting in behaviors that may compromise safety, treatment adherence, or community integration.

Identify the client's **observable impulsivity risk** level based upon clinical evaluation as being:

- **Low** — Occasional impulsive thoughts or minor behaviors without safety impact (e.g. follows directions with minimal redirection, can tolerate frustration without escalation, rarely engages in unsafe/disruptive actions).
- **Moderate** — Impulsive behaviors occur intermittently and may interfere with functioning (e.g. verbal outbursts, poor judgement in social decisions, requires occasional prompts/redirection to maintain safety/focus, difficulty delaying gratification, etc.).
- **High** — Frequent or persistent, impulsive behaviors that pose safety or community stability risks (e.g., frequently acts without regard for consequences / safety, displays aggression or makes threats, risk for elopement or absconding, limited ability to pause or use coping strategies without intensive support, etc.).
- **N/A (Not applicable)** –- No history or current evidence of impulsive behaviors.

Community Treatment Supports

Purpose: To identify the assigned Managed Care Organization (MCO) or Administrative Services Organization (ASO) responsible to assist with transition and support the client in the community (e.g. substance use disorder counseling / treatment, outpatient mental health support, sex offender counseling / treatment, etc.).

Utilizing the check box, indicate client's delivery system.

If assigned to an MCO or ASO, list name of entity. If applicable, provide the liaison's name, email address and phone number.

Suggested community treatments: Please list or identify community treatment supports that will aid the client in a successful community transition.

For Inpatient Behavioral Health and Habilitation Administration (BHHA) Clients Only

This section only pertains to clients who are currently receiving inpatient psychiatric care from Eastern State Hospital, Western State Hospital, Maple Lane, or Olympic Heritage Behavioral Health.

Please check "Yes" or "No" and provide a date completed if a **Civil Discharge Review** is required.

Check boxes for Legal Involvements: Mark the appropriate boxes to indicate which legal status issues impact the client. Additionally, provide all known information for any legal notification requirements.

Lastly, provide the **alleged index offense(s)** that led to the current hospitalization.

Behavior Snapshot

Purpose: Completed collaboratively between the HCS case manager and assigned inpatient setting discharge planner or social worker. Provide comprehensive information critical to successful and effective transition planning. This section is to identify both historical and current behaviors and should align with the following behaviors found in the CARE Assessment. It is also intended to capture information on known trigger(s) to each behavior and the effective and individualized intervention(s) to best support the client.

Symptoms of Distress	Many incidences of uncontrollable crying, tearfulness
	Easily irritable / agitated requiring intervention
	Obsessive regarding own health / body functions
	Non-health related repetitive anxious complaints / questions
	Unrealistic fears & suspicions
Inappropriate / Unsafe Behaviors	Inappropriate nakedness
	Eats non-edible substances/objects > 1 month (pica)
	Deliberate fire setting behaviors
	Inappropriate toileting/menses activity
	Intentional self-injury
	Left home & gotten lost
	Law breaking activities
	Sexual acting out
	Inappropriate spitting
	Unsafe cooking
	Unsafe smoking
	Disrupts household at night requiring intervention

Verbal Agitation/Aggression	Accuses others of stealing
	Inappropriate verbal noises causing distress to others
	Resistive to care with words/gestures
	Uses offensive language
	Verbally abusive
	Yells/screams
Physical Agitation/Aggression	Assaultive-Not during personal care
	Combative during personal care
	Hides items/Hoards items/Accuses others of stealing
	Intimidating/threatening (no physical contact)
	Rummages/Takes other's belongings
	Deliberate sexual violence
	Wanders-Exit seeking
	Wanders-Not exit seeking
Severe Affective Dysregulation	Delusions
	Hallucinations
	Manic episodes of at least a week
	Extreme / rapid mood swings

If the client is experiencing a behavior outside of the above list, please include it in the client's behavior snapshot and note it in the client's CARE Assessment.

Current Status: Provides information on whether the behavior is current or historical with the date of last occurrence by month and year (e.g. May 2019).

Frequency: Utilize the checkboxes to indicate if the behavior occurs daily, weekly, or less than weekly. If the behavior is noted as less than weekly, provide the date of last known occurrence by month and year (e.g. June 2024).

Management: Use the checkboxes to indicate the current phase of management for each noted behavior that best describes the effectiveness of the current treatments / interventions.

Trigger(s) / Intervention(s): Please provide any known triggers for the identified behavior along with the *specific* intervention(s) utilized to address the behavior or for historical behaviors, provide known trigger(s) and the intervention(s) that successfully addressed it.

Copies will be kept in the:

- Client record.

Case manager / social worker responsibilities:

- Review Pages 1 and 2 of this this form prior to scheduling assessment
- Coordinate / meet with the assigned inpatient social worker or discharge planner following the in-person CARE assessment to complete the Behavior Snapshot section of this form.
- SER note the date that the Behavior Snapshot portion is completed and the inpatient staff member who assisted with completion.

Inpatient setting responsibilities:

- Complete Pages 1 and 2 of this form and include it as a part of a complete referral packet for HCS services.
- Coordinate / meet with assigned HCS case manager to complete the Behavior Snapshot portion of this form following the in-person CARE assessment.
- Collaborate with the HCS case manager via telephone, email, or in-person to support the assessment and transition processes.
- Inform DSHS of any change of conditions for the client.