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 (including area code) | |

**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 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:

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:

## Legal Status

Current commitment type:

Current Court Order expiration date:

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

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

Sex Offense registration requirement? ☐ Yes ☐ No RSO Level:

Active warrants? ☐ Yes ☐ No ☐ Unknown

Active No Contact orders? ☐ Yes ☐ No

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

**Behavior Snapshot**

**The Behavior Snapshot is to be 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 current status, frequency, and management status of these behaviors, along with any effective individualized interventions. Examples of behaviors to include are: Repetitive movements, sexual acting out, delusions, hallucinations, combative during personal care, verbally abusive, etc. For a more comprehensive list of behaviors, please reference the Instructions section.

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

| | | | | |
|---|---|---|---|---|
| | ☐ Current<br>☐ Historical<br>Date of last occurrence: | ☐ Daily<br>☐ Weekly<br>☐ Less than weekly<br>Date of last occurrence: | ☐ Active - Limited responsiveness to intervention<br>☐ Active—Responsive to intervention<br>☐ Stable / Managed with current treatment plan<br>☐ Resolved / Historical | |
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| **Attestation Signatures** | | | | |
| Social Worker's Signature | | Date | Social Worker's Printed Name | Phone Number (with area code) |
| HCS Case Manager's Signature | | Date | HCS Case Manager's Printed Name | Phone Number (with area code) |

## Instructions for Individualized 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 for Transition Planning

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

- For each item, check "Yes" or "No" to indicate known history, collateral information or patient report of suicide attempts, assault history, and homicidal ideation. Additionally, provide detail of any known history of suicidal ideation or behavior, assaultive behavior, or homicidal ideation / violent behavior for effective community transition.
- 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.

  Based upon this definition, please 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

The purpose of this section is to identify any assigned Managed Care Organization (MCO) or Administrative Services Organization (ASO) that is 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 (e.g. sex offender counseling / treatment, substance use disorder counseling / treatment—including methadone treatment, outpatient mental health services, etc.).

| Legal Status |
|---|
| **Check boxes for Legal Involvements:** Mark the appropriate boxes to indicate which legal status issues impact the client.<br>**Active Warrants:** Only identify “Yes,” “No,” or “NA”.. It is important for any potential provider to be aware of existing warrants and the plan to address, as this will be part of transition planning. |

## Behavior Snapshot

The Behavior Snapshot will be completed collaboratively between the HCS case manager and assigned inpatient setting discharge planner or social worker. Comprehensive information is critical to successful and effective transition planning. This section is to identify both historical and current behaviors.

| Category | Behavior |
|---|---|
| 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 |

| Category | Behavior |
|---|---|
| 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.

**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.

**Interventions**: Please provide the specific interventions utilized to address the behavior or for historical behaviors, provide the interventions that successfully addressed it.

## Attestation Signatures

Please note that by signing this document, you agree that you have reviewed and confirmed the information it contains.

**Hospital social worker / discharge planner signature:** Signature of the staff completing the form and the date it was completed.

**HCS case manager signature:** Signature of the assigned case manager completing the form and date that it was completed.

Copies will be kept in the:

- Client record.

Case manager / social worker responsibilities:

- Review Pages 1 and 2 of this this form thoroughly prior to scheduling assessment
- Meet with the assigned inpatient social worker or discharge planner following the in-person CARE assessment to collaboratively complete the Behavior Snapshot section of this form.

Inpatient setting responsibilities:

- Complete Pages 1 and 2 of this form and include it in the referral packet for HCS services.
- Make time to meet with assigned HCS case manager to complete the Behavior Snapshot portion of this form following the in-person CARE assessment.
- Inform DSHS of any change of condition for the client.