CONTRA COSTA
ALCOHOL & OTHER
DRUGS SERVICES
A Program of Behavioral Health Services

Discharge Summary

NAME / MRN

Program Name:		Discharge Date:	Admission Date:
Facility ID:	Program ID:	Date of Last Face-to-Face Session:	

☐ **Interpreter Name of Interpreter:** _____

Language service provided in other than English: ☐ Spanish ☐ Other_____

Discharge Status

I. Reasons for Discharge. Check all that apply:

- ☐ Completed treatment goals/plan at this level of care
- ☐ Designated SUD level of care not available at this time
- ☐ Discharged into more appropriate Behavioral Health system of care
- ☐ Discharged by agency for due cause (e.g. non-compliance with agency rules)
- ☐ Left before completing treatment goals/plan with satisfactory progress
- ☐ Left before completing treatment goals/plan with unsatisfactory progress
- ☐ Does not meet SUD Medical Necessity for this level of care. If Beneficiary does not meet Medical Necessity for Program Level of Care, what actions were taken?

Additional Reasons for Discharge:

- ☐ Death
- ☐ Incarceration
- ☐ Other: _____

II. Beneficiary Prognosis upon Discharge (Check one box and describe in narrative format):

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unstable

III. Description of Beneficiary Discharge Plan:

NAME / MRN

IV. Narrative Summary of Treatment Episode

Summarize presenting problem, treatment provided, and final outcomes. The narrative summary must include:

- **Current Drug Usage**
- **Legal Status/Criminal Activity**
- **Vocational/Educational Achievements**
- **Living Situation**
- **Referrals**

All of these Five (5) components **MUST BE ADDRESSED.** If not, the discharge summary is **DEFICIENT** under the Alcohol and Drug Treatment Certification Standards. If a component is Not Applicable, list it and state the component is not applicable. If this space is insufficient for your summary, please continue documenting on the back of the page.

V. Fair Hearing Rights Citation

Was the client advised of their 42 CFR, 438.10 Fair Hearing Rights if the discharge was involuntary?

Check one: ☐ **YES** ☐ **NO** ☐ **N/A** Date:_____

☐ **Notice of Adverse Benefit Determination Issued**

AOD Counselor/LPHA Printed Name:	**AOD Counselor/LPHA Signature:**	**Date:**
Beneficiary Printed Name:	**Beneficiary Signature:**	**Date:**

If no signature, indicate reason:

* If the Beneficiary is unavailable to sign this document, the counselor must document efforts to contact the person.