Administrative Policy

1 Discharge

1.1 The ID Team (Clinical Team), including the person served, when possible, will participate in discharge planning. Such planning will be reflective of the ISP. As a person achieves ISP goals, discussions will begin regarding transition planning and movement to a less restrictive environment.

1.2 Persons will be discharged for the following reasons:

1.2.1 The person has met their primary goals which resulted in the admission to the program.

1.2.2 The person is no longer benefitting from services despite efforts to improve and motivate the person.

1.2.3 The person chooses to no longer receive services from OPTIONS.

1.2.4 The person is a danger to themself and/or others. In some cases this may require a three day notification due to the extreme nature of the situation. If the person requiring a three day notice resides in a CDPH or CCL licensed home, CDPH or CCL will be notified of the request.

1.2.5 The person may be discharged if funding is discontinued.

1.2.6 The person requires a higher level of care than may be provided in that level of service.

1.3 When the IDT determines a discharge notice is necessary, a written discharge notice, as outlined in the individual admission agreement, will be provided to the person served, their conservator if applicable, and the Regional Center Service Coordinator. If the person resides in a CDPH or CCL licensed home, CDPH or CCL will also be notified of the request.

1.4 If a person served determines they would like to discontinue services, they are asked to provide a 30 day written notice as agreed upon in the admission agreement.

2 Discharge Planning

2.1 Discharge planning will be flexible and change according to the ongoing needs of the person served. The process of planning for discharge will be evaluated at regular intervals and become more formal and documented when a person is close to actually leaving from the service. In some cases, a transition plan may be developed as a link to the current services and discharge summary.

2.2 The goal of the plan is to incorporate the needs and supports necessary for the person to reside in the least restrictive environment of their choice.

2.3 When a person is discharged, a discharge summary will be written that includes:

2.3.1 The original reason why a person was referred for the level of services provided.

2.3.2 The interventions/techniques that were successful.

2.3.3 Recommendations which may include: future services, follow-up on interventions/techniques utilized, medical follow-up, and/or issues/concerns to monitor.

POLICY DATE:	July 2004
REVISED:	January 2008
	December 2008
	May 2012
	April 2014
	October 2015
	November 2016
	October 2017
REVIEWED:	October 2018
REVIEWED:	November 2019
	November 2020
REVISED:	January 2022
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