

Model Care Coordination Plan¹

Patient's Name: _____
Medical Record Number: _____
Date of discharge: _____

Model Care Coordination Plan: Patient Rights and Instructions

As required by state law², as the patient you must be provided a scheduled follow-up appointment and referral for further care before discharge from this facility. The facility is not permitted to involuntarily hold you longer than otherwise permitted solely because of the requirement to provide a follow-up appointment.

You are encouraged to accept a follow-up appointment but have the right to refuse. California law requires state-regulated health plans to provide timely access to care. This means that there are limits on how long you must wait to get health care appointments and telephone advice. If you have a problem getting timely access to care, you should call your health plan.

Discharge Disposition (choose one)³

☐ Unhoused

(Describe): _____

☐ Shelter with supportive services

(Describe): _____

☐ Home

☐ Home with family/supportive person(s)

☐ Facility (Name, address, and type)

(Describe): _____

Other

(Describe): _____

☐ Decline to state

(Describe): _____

Diagnosis: _____

Expected course of recovery: _____

¹ Welf. & Inst. Code §§ 5257.5, 5402.5(c)(2)

² Welf. & Inst. Code §§ 5152(c)(1), 5257.5(a), 5361(c)(2); see Welf. & Inst. Code § 5402.5(b)(2)

³ Health & Safety Code 1262 and 1262.5

Recommended follow-up: _____

Medications prescribed and side effects and dosage schedules (*a signed informed consent form for medications, if attached to this form, may satisfy this requirement*): _____

Recommendations regarding treatment that are relevant to the patient's care: _____

Other information/instructions: _____

Legal Status

Current Legal Status upon discharge: ☐ Voluntary ☐ LPS Conservatorship

A model care coordination plan is required for any individual who is being discharged from an Lanterman-Petris-Short (LPS) designated facility who has been detained under the LPS Act on a hold or conservatorship.

Please identify the type of legal status that applied to this individual prior to discharge (required):

Type of Involuntary Hold: _____ County where hold was placed: _____
Date when hold was placed: _____ Time (if applicable): _____ ☐ AM ☐ PM
Date the hold ended: _____ Time (if applicable): _____ ☐ AM ☐ PM

Type of Conservatorship: _____ County where conserved: _____
Date when conservatorship was established: _____ Date when conservatorship was ended: _____

Referrals and Follow-Up Services

Referrals may include, but are not limited to, informing the person of available services, making appointments on the person's behalf, discussing the person's service needs with the agency or individual to which the person has been referred, appraising the outcome of referrals, and arranging for personal escort and transportation when necessary. Referral shall be considered complete when the agency or individual to whom the person has been referred accepts responsibility for providing the necessary services.

Select one option:

- ☐ The **discharging facility** has set up a follow-up behavioral health appointment for you. Based on the information provided regarding your insurance and the recommendations provided by your treatment team, you have been provided with the following appointment.

Provider Name: _____

Appointment Address (or location): _____

Appointment Date & Time: _____

Appointment Service Delivery (*Telehealth/In Person*): _____

Provider Contact: _____

Planned Means of Transportation to Appointment (*if known*): _____

Services to be provided: _____

Please let your provider know if you need any translation of information or need any transportation assistance to attend your follow up appointment. Your provider may talk to you about transportation resources that may be available to you.

Language Assistance Needed? ☐ Yes ☐ No | If yes, please describe: _____

Transportation Assistance Needed? ☐ Yes ☐ No | If yes, please describe: _____

Disability/other accommodations needed? ☐ Yes ☐ No | (If yes, please describe): _____

- ☐ Despite our best efforts, a follow-up behavioral health appointment was unable to be scheduled and would have delayed discharge. For follow up care please contact:

Contact Name/Organization: _____

Phone number: _____

Email (if applicable): _____

Address (if applicable): _____

Why the appointment was not able to be scheduled: _____

- ☐ Patient declined follow up appointment

Other Patient Referrals

Name/Agency: _____

Address: _____

Phone: _____

Comments: _____

Name/Agency: _____

Address: _____

Phone: _____

Comments: _____

Name/Agency: _____

Address: _____

Phone: _____

Comments: _____

Care Coordination Team Information

NOTE: Pursuant to state law⁴, care coordination is a shared responsibility between, at minimum, the county, the facility, the individual receiving treatment, and the responsible health insurance plan, if the county is not the responsible party.

Care Coordination Team Information:

This care coordination plan should identify who will be on the care team and the roles of each entity to ensure continuity of services and care.

Discharging facility:

Role of the discharging facility: _____

Facility Care Team: _____

Contact Information: _____

Email: _____

Phone: _____

Address: _____

County in which person was placed on hold:

Role of the County: _____

County Care Coordination Contact Name/Title: _____

Contact Information: _____

Email: _____

Phone: _____

Address: _____

Responsible Health Plan:

Role of the Health Plan: _____

Contact Information: _____

Phone: _____

Address: _____

Post-Discharge Mental Health Provider(s):

Role of provider: _____

Psychiatrist: _____

Other treatment provider(s): _____

Contact Information: _____

Phone: _____

Address: _____

Coverage/Payer (name of insurance or Medi-Cal plan): _____

Coverage Type: ☐ Medi-Cal ☐ Medicare ☐ Commercial ☐ Self-Pay ☐ Other

Post-Discharge Substance Use Disorder Treatment Provider(s):

Role of SUD treatment provider: _____

Contact Information: _____

Phone: _____

Address: _____

Coverage/Payer (name of insurance or Medi-Cal plan): _____

Coverage Type: ☐ Medi-Cal ☐ Medicare ☐ Commercial ☐ Self-Pay ☐ Other

Primary Care Provider(s):

Role of primary care provider: _____

Contact Information: _____

⁴ Welf. & Inst. Code §§ 5257.5, 5402.5(c)(2)

Phone: _____

Address: _____

Coverage/Payer (name of insurance or Medi-Cal plan): _____

Coverage Type: ☐ Medi-Cal ☐ Medicare ☐ Commercial ☐ Self-Pay ☐ Other

Comments: _____

(NOTE: If any item listed above is not completed, explain why in the comments area.)

Date: _____

Name of person preparing this aftercare plan: _____

Title of the person preparing this aftercare plan: _____

Contact information of the person preparing this aftercare plan: _____

You have the right to designate someone to receive a copy of this plan on your behalf.

Patient's designation to receive a copy of this plan: ☐ Declines ☐ Designates the following person(s):

Name: _____

Designated Person Role (if applicable): _____

Phone: _____

Email: _____

Mailing Address: _____

City/State/Zip: _____