**San Diego County Mental Health Services**

**Short-Term Residential Program (STRTP)**

**TRANSITION DETERMINATION PLAN**

**\*Client Name:** **Client Preferred Pronouns:**

**\*Case #:**       **\*STRTP Name:**

**\*Date of Admission:**       **\*Anticipated transition date:**

* Transition Determination Plan to be completed within 14 days prior to child or youth’s transition from the STRTP*.*

**\*1. REASON FOR ADMISSION:** *Describe events in sequence leading to admission to your program. Describe primary need upon admission*:

**\*2. REASON FOR DISCHARGE FROM STRTP PLACEMENT:** *Choose most appropriate reason for transition. If selecting Other or Alternate STRTP/Residential Setting, provide explanation for reason for transition:*

Higher level of care  Lower level of care  Client did not return/AWOL

Alternate STRTP/Residential Setting  Other *Explain*:

**\*3. LIVING PLACEMENT UPON DISCHARGE FROM STRTP**: *Choose most appropriate placement. If other provide explanation of living placement:*

Biological Family  Extended Family Member  Non-Related Extended Family Member

Resource Family Foster Family Agency  Extended Foster Care/Transitional Housing Program  San Pasqual Academy  Alternate STRTP  Other *Explain*:

Specific Name of caregiver and relationship to youth:

**\*4. COURSE OF TREATMENT DURING THE CHILD’S ADMISSION:** *Include mental health treatment interventions and the child or youth’s response. Include the child’s transition plan goals and child’s progress toward those goals*

**\*5.** **MENTAL HEALTH DIAGNOSIS AND FOLLOW UP REQUIRED:**

**a.** Current Diagnosis: *List all diagnosis in order of priority*

**b.** Symptoms related to diagnosis and follow up required:

**c.** Goals and expected outcomes for follow up treatment:

**\*6. RECOMMENDATIONS REGARDING TREATMENT THAT IS RELEVENT TO THE CHILD’S CARE:** *Review with child or youth prior to transition. Use child or youth’s own language when applicable.*

a. Resiliency Strategies:

* Preferred activities or hobbies
* Soothing or calming techniques
* Identified sources of support (person, place, object)
* Caregiving strategies that promote resiliency
* Other

b. Triggers: *Include social, emotional or environmental factors that may decrease the child or youth’s ability to be successful in next placement.*

c. Other: *Any other pertinent information which will enhance the child or youth’s successful transition.*

**\*7. SUBSTANCE USE TREATMENT RECOMMENDATIONS:**

Not Applicable  Yes *explain*:

**\*8. MEDICAL INFORMATION:**

*a. Medical and Dental Services Received While Residing in the STRTP*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Service | Date | Follow Required (yes/no) | Next Appointment Date | Next Appointment Time | Upcoming Due Dates (If no appt. scheduled) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. *Current Medications (Non-Mental Health)*

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |

1. *Psychotropic Medications - Attach documentation from prescribing physician, such as JV220, for potential and reported side effects of medication*

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |

1. *Allergies and Adverse Medication Reactions*

**\*9. EDUCATIONAL INFORMATION***: Include grade, grade level functioning, educational needs, education plans (for example IEP or 504 plan) and follow up required.*

a. Current grade:

b. Educational strengths:

c. Educational needs:

d. Educational Plans (i.e. Individualized Education Plan, 504 plan, other):

e. Date the school was notified of discharge from the STRTP:

**\*10. REFERRAL(S)**:

Wraparound  TBS  FFAST  CASS  School-Based Therapy  Outpatient Mental Health Clinic  TERM Provider Teen Recovery Center (TRC) Incredible Families  Other explain:

Referral Contact Information:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Service | Program Name | Program Contact Name | Program Contact Phone Number | Appointment Date if Applicable |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Client or caregiver declined referral(s)

**Explained in client’s primary language of**:

**No**  (if no, document reason):

**Client offered a copy of the Transition Determination Plan**:

**Yes**

**No**  (if no, document reason):

**Copy of Transition Determination Plan offered to:** (Check the following as applicable. Copy shall be made available to at least one of the following)

**Parent**  **Conservator**  **Guardian**  **Other**  If other, relationship:

**Copy of Transition Determination Plan offered to:** (Copy shall be made available to one of the following)

**Placing Agency Representative:**  CWS PSW  Juvenile Probation Officer

**Placing Agency Representative Contact Information:** Name      Phone Number

**Date Placing Agency Representative notified of transition from the STRTP: ­­­­­­**

**SIGNATURES:**

**Client:** **Date**:

**Unable to obtain Explanation:**

**Date:**

**Signature of Staff Completing Transition Determination Plan**

**ID Number:**

**Printed Name**