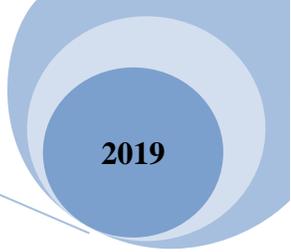


# San Diego County Mental Health Services

## Short-Term Residential Therapeutic Program (STRTP)

### Discharge Summary



2019

**WHEN:** Completed and signed within seven (7) days after child’s/youth’s discharge from a Short-Term Residential Therapeutic Program

**ON WHOM:** All children/youth placed in the STRTP

**COMPLETED BY:** Licensed/Waivered Psychologist  
 Licensed/Registered/Waivered Social Worker  
 Licensed/Registered/Waivered Marriage and Family Therapist  
 Licensed/Registered Professional Clinical Counselor\*\*

**MODE OF COMPLETION:** Entered in the Electronic Health Record (EHR).

**REQUIRED ELEMENTS:**

- Client name:** enter the client’s full name.
- Case number from the EHR:** Enter the client’s unique client number.
- STRTP name:** Enter the name of the STRTP facility.
- Date of admission:** Enter the date the client was admitted to the program.

**1. Discharge Date from STRTP**

- Enter the date the child/youth was discharged from the STRTP. This is the date of the child or youth transitioned from the STRTP to an alternate placement.
- Do not include aftercare services in the Discharge Date.

**2. Aftercare provided by the STRTP**

- Check Yes or No to indicate if aftercare services were provided by the STRTP.

**3. Discharge date from Aftercare**

- Enter the date the child/youth was discharged from aftercare services.
- If aftercare services were not provided, mark N/A.

**4. Summary of Services provided during aftercare**

- If aftercare services were not provided mark N/A.
- If aftercare services were provided, summarize services provided during aftercare. Include treatment interventions used to promote stability in placement, client’s response to interventions, and outcomes of aftercare treatment provided. Also include recommendations for continued treatment if applicable.

**5. Discharge Reason**

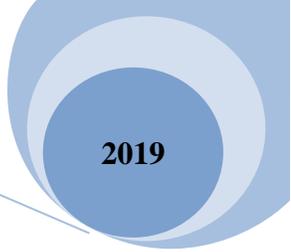
- Enter the most appropriate reason for discharge by selecting from the Table below:

<b>Reason for Discharge</b> 1-Requires Higher Level of Care 2-No longer requires services at this level of care 3-Lost Contact 4-Ineligible for services/does not meet medical necessity 5- Moved Away from Service Area 6- Change in Medical Insurance 7- Client Receiving Services/Tx Elsewhere	8- Client/Family Dissatisfied 9-Left Against medical Advice 10-Refused services 11-Death- suicide 12-Death- non-suicide 13-Incarcerated 14-Other
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# San Diego County Mental Health Services

## Short-Term Residential Therapeutic Program (STRTP)

### Discharge Summary



- If a child/youth transitions to a family or home-based placement select #2 - No longer requires services at this level of care.
- If a child/youth is hospitalized or transitions to an alternate STRTP select #1 - Requires higher level of care.
- If the answer is Other, Specify the reason.

**6. Discharge Destination**

- Enter the most appropriate response in the space provided from choices listed in the Table below:

A- Transferred to Primary Care Physician	D- Transferred to LOWER level of care	G-Unknown: Never returned
B- Transferred to EQUIVALENT level of care	E- Self-care/family/general community support	H- Unknown: Not eligible for services
C- Transferred to HIGHER LEVEL of care	F-Unknown: Referred to non-county services	I-Jail/Prison
		J-Not applicable
		K-Other

- If a child/youth transitions to a family or home-based placement select E – Self-care/family/general support
- If a child/youth transitions to an alternate STRTP within San Diego County select B – Transferred to EQUIVALENT level of care.
- If a child/youth transitions to an alternate STRTP outside of San Diego County select C – Transferred to HIGHER LEVEL of care.
- If other provide explanation of destination at discharge.

**7. Were Client plan goals met?**

- If the client has not met at least 50% of the Client Plan goals (including leaving treatment prior to completing goals), select No.
- If the client has met all goals, select Yes.
- If the client has met at least 50% of goals, select Partially.
- If no goals were established prior to discharge, select No Goals Established.

**Signature of Clinician Requiring Co-signature/Signature of Clinician Completing/Accepting the assessment:**

Print, Sign and date the assessment in the appropriate signature section include CCBH ID number

**BILLING:** Can only occur when connected to a direct client service.

\*\*Note: Programs within the CYF SOC must verify that all training requirements have been met in order for an LPCC/PCI to provide services to youth and families.