



Behavioral Health Administration
55 Wade Avenue - Dix Building SGHC - Catonsville, Maryland 21228

**RESIDENTIAL REHABILITATION PROGRAM
DISCHARGE INFORMATION FORM**

Consumer's Name: _____
Consumer's ASO member #: _____ Consumer's Date of Birth: _____
RRP Provider's Name: _____
Consumer's RRP address: _____

Consumer's level of care while in RRP: Specialty Bed Designation:
General: None: Deaf: ITCOD:
Intensive: TAY: DD/MH: Geriatric:

Date of admission to RRP: _____

Date of discharge from RRP: _____

Type of discharge: Initiated by:
Planned: Consumer:
Unplanned: Program: Mutual Plan:

Was the Core Service Agency (CSA)/Local Behavioral Health Authority (LBHA) involved with the Discharge/Transition Plan? Yes No

Briefly describe circumstances of discharge: _____

If an unplanned discharge, was a Management Intervention Plan (MIP) designed and implemented in conjunction with the CSA/LBHA: Yes No

Address at time of discharge: _____

Briefly describe transition plan: _____

Level of Care (LOC) discharged to:	Type of Housing Discharged to:	Date of Occupancy: _____
____ Case Management	____ Independent Living	
____ Outpatient Mental Health Center	____ Permanent Supported Housing Program	
____ Private Psychiatrist/Therapist	____ Assisted Living Home	
____ Supported Employment	____ Living with Family/Friends	
____ General Hospital facility (medical)	____ Transitional Housing Program	
____ General Hospital facility (psychiatric)	____ Homeless Shelter	
____ Rehabilitation facility/Nursing Home	____ Other housing (describe): _____	
____ ACT/or Mobile Treatment Services	____ Consumer refused services	
____ Substance Use Services – inpatient or outpatient		
____ Psychiatric Rehabilitation Program onsite or offsite	Date of Initiation of Service (LOC): _____	
____ State Psychiatric Hospital	Name of Service Provider: _____	
____ Residential Crisis Bed	Site Location: _____	

Signature of RRP Staff: _____ Title/Credentials: _____

Printed Name: _____ Phone #: _____

Date Submitted to CSA/LBHA: ____ / ____ / ____