**Section 300.4060 Discharge Plans for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S**

a) As part of the ITP, a discharge plan shall be considered by the interdisciplinary team as a component of the individual's comprehensive program plan. This plan shall address the reduction of symptoms and the acquisition of behaviors and prioritized skill deficits that inhibit the individual from moving to a more independent environment.

b) Within one year prior to a planned discharge, preparation shall address:

1) Identification and linkage to proposed community providers;

2) Self-directed initiation and compliance with mental health services while in the facility;

3) Use of community mental health services;

4) Assistance with locating and securing housing; and

5) Assistance with identification, application and securing financial resources.

c) At least 30 days before the individual's planned discharge, the PRSC shall notify the individual or the individual's legal representative and, when appropriate, the individual's family, both orally and in writing, of the upcoming planned discharge. A specific, individualized post-discharge plan must be developed by the IDT, and, when appropriate, with input from community support agencies, family and friends, 30 days before the planned discharge. The plan will identify:

1) The alternative living site;

2) Financial resources available;

3) Community service needs and availability;

4) Community mental health services with scheduled psychiatric appointments;

5) Access to medical care and medications; and

6) Case management system responsible for transition and follow-up.

d) The discharge plan shall consider the resident's geographic preference upon discharge and the need for financial assistance.

e) Referral and linkage to the post-discharge service provider should occur with face-to-face contact, on-site visits, and, if appropriate, assumption of partial services prior to discharge.

f) At the time of discharge, the facility shall:

1) Prepare a discharge summary of the resident's current psychiatric status; self-care skills; behavior and impulse control; social functioning; community living skills; basic educational, vocational and work-related skills; substance abuse history; and general health status. Dates of resident's pre-discharge contact with the aftercare agency shall be included, as well as specific issues that may have a negative impact on community adjustment. The discharge plan shall also include recommendations for transitional programming and the name, address, telephone number, and time and date of the resident's first post-discharge appointment with the aftercare service provider.

2) Provide the post-discharge plan of care and the discharge summary to the resident's new service provider.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)