Mental Health/Substance Abuse

GUIDELINES FOR DISCHARGE OF RESIDENTS FROM A
STATE CIVIL MENTAL HEALTH FACILITY TO THE COMMUNITY

1. **Purpose.** This operating procedure describes procedures to be followed when planning for and discharging a resident to the community from civil mental health treatment facilities operated by the state or via a contract with a provider.

2. **References.**
   
   a. Chapter 394, Florida Statutes (F.S.), Florida Mental Health Act.
   
   b. Chapter 916, F.S., Mentally Deficient and Mentally Ill Defendants.
   
   c. Chapter 744, F.S., Guardianship.
   
   
   e. Chapter 400, F.S., Licensed Facilities.
   
   f. Rule 65E-5, Florida Administrative Code (F.A.C.), Mental Health Act Regulations.
   
   g. CFOP 155-18, Guidelines for Conditional Release Planning for Individuals Found Not Guilty By Reason of Insanity or Incompetent To Proceed Due to a Mental Illness.
   
   h. CFOP 155-22, Leave of Absence and Discharge of Residents Committed to a State Mental Health Treatment Facility Pursuant to Chapter 916, F.S.
   
   i. CFOP 155-13, Incompetence to Proceed and Non-Restorable Status.
   
   j. CFOP 155-58, Guidelines for Assisting State Mental Health Treatment Facility Residents Who May Benefit from Appointment of Public Guardianship.

3. **Scope.** This operating procedure applies to persons residing in a state civil mental health treatment facility committed pursuant to Chapter 394, F.S., or pursuant to Chapter 916, F.S., due to mental illness.

4. **Definitions.** As used in this operating procedure, the following terms shall mean:

   a. **Benefits Coordinator.** An employee in the SAMH Headquarters Office, Continuity of Care Unit. The Benefits Coordinator provides technical assistance about the eligibility criteria and benefits status to the facility liaison at the State Mental Health Treatment Facility for residents who are being discharged to the community.
b. **Community Representative.** An individual who works with residents and their families, community service providers, and the recovery team to ensure continuity of care. The Community Representative assesses resident needs, plans services, links the resident to services and supports, assists in securing community placement, monitors service delivery and evaluates the effectiveness of service delivery. The community liaison, FACT Team leaders/case managers, forensic specialist, forensic case manager, and any other community staff may function as a civil or forensic resident’s Community Representative.

c. **Conditional Release.** A court approved discharge for a resident committed under Chapter 916, F.S., from a state mental health treatment facility to a less restrictive community setting.

d. **Conditional Release Plan.** A court ordered plan for providing appropriate outpatient care and treatment for individuals found Incompetent to Proceed or Not Guilty by Reason of Insanity. The committing Court may order a Conditional Release of any defendant in lieu of an involuntary commitment to a state mental health treatment facility, or upon a recommendation that outpatient treatment of the defendant is appropriate. A written plan for outpatient treatment, including recommendations from qualified professionals, must be filed with the Court with copies to all parties. Such a plan may also be submitted by the defendant and filed with the Court with copies to all parties.

e. **Direct/Community Discharge.** The planned release of a resident to the community under the direction of the mental health treatment facility administrator and/or designee.

f. **Discharge Plan.** A document developed by the resident, recovery team, guardian (if applicable) and the resident’s Community Representative which finalizes the discharge planning process and serves to guide the continuing services the resident needs and wants when discharged to the community.

g. **Discharge Ready.** The resident’s psychiatric condition has improved so that the resident no longer requires continued inpatient psychiatric treatment.

h. **Express and Informed Consent (hereafter referred to as consent).** Permission voluntarily given in writing by a capable person, after sufficient explanation and disclosure of the subject matter involved, to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

i. **Facility Liaison (CFOP 155-27).** Staff of the mental health treatment facility who, in conjunction with the Community Representative, is responsible for coordination of benefits and/or community discharge planning for the resident. In some facilities, these functions may be performed by the human services counselor or benefits coordinator. Facility staff or the local Social Security Administration office will provide training on facility specific discharge processes including benefits coordination during orientation. Training will be provided at least annually on any updates or changes to the pre-release agreement.

j. **Forensic Specialist/Forensic Case Manager.** A staff member employed by a community mental health provider, under contract with a Managing Entity, to provide an array of services to individuals who have been committed to the Department of Children and Families pursuant to the provisions of Chapter 916, F.S., by one of the state’s twenty circuit courts. Specifically, these are individuals who have been adjudicated as Incompetent to Proceed (ITP) or Not Guilty by Reason of Insanity (NGI) due to mental illness.

k. **Guardian.** As defined in s. 744.102(9), F.S., a person who has been appointed by the Court to act on behalf of a resident or property, or both.
I. **Incompetent To Proceed (ITP).** A determination made by the Circuit Court that an individual is unable to proceed at any material stage of a criminal proceeding. These stages shall include pretrial hearings and trials involving questions of fact on which the defendant might be expected to testify. It shall also include entry of a plea, proceedings for violations of probation or violation of community control, sentencing, and hearings on issues regarding a defendant’s failure to comply with court orders. It shall also consider conditions or other matters in which the mental competence of the defendant is necessary for a just resolution of the issues being considered.

m. **Level of Care Utilization Scale (LOCUS).** A quantifiable measure used to guide individual assessments resulting in level of care decisions. The LOCUS consists of six clinical and rehabilitative dimensions for composite scoring which corresponds with a particular level of care. Training on the administration and use of the LOCUS is required for all recovery team members providing input into the scoring of the LOCUS.

n. **Managing Entity (ME).** As defined in s. 394.9082(2)(b), F.S., an entity that manages the delivery of behavioral health services.

o. **Mosher v. State.** A 2004 1st DCA ruling (876 So.2d 1230) which requires civil commitment proceedings or release from commitment when a defendant remains without a substantial probability of regaining competency in the foreseeable future, and the defendant has less than five years of involuntary commitment under section 916.13, Florida Statutes.

p. **Not Guilty By Reason of Insanity (NGI).** A determination made by the Circuit Court that an individual is acquitted of criminal charges because the individual is found insane at the time of the offense.

q. **Pre-Discharge Ready.** The resident’s Recovery Team believes the resident is likely to be “Discharge Ready” within the next three (3) months.

r. **Resident.** Person who receives mental health treatment services in a civil mental health treatment facility operated by the state or via a contract with a provider. The term is synonymous with “client”, “consumer”, “individual”, “patient”, or “person served”.

s. **Recovery Plan.** A written plan developed by the resident and his or her recovery team. This plan is based on assessment data, identifying the resident’s (individual) clinical, rehabilitative and activity service needs. The plan further identifies the strategy for meeting those needs, documents treatment goals and objectives, establishes criteria for terminating the specified interventions, and documents progress in meeting specified goals and objectives.

t. **Recovery Team.** An assigned group of individuals with specific responsibilities identified on the recovery plan, including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), Community Representative, family member and other treatment professionals as determined by the resident’s needs, goals, and preferences.

u. **Resident Advocate.** An individual whose primary job is to assist the resident in meeting the resident’s expressed needs separate and apart from the Recovery Team process.

v. **State Mental Health Treatment Facility.** A facility operated by the Department of Children and Families or by a private provider under contract with the Department to serve individuals committed pursuant to Chapter 394, F.S., or Chapter 916, F.S.
5. Responsibilities.

   a. Facilities. It is the responsibility of facilities to accept persons for psychiatric care pursuant to the provisions of Chapter 394, F.S., or Chapter 916, F.S. Facilities will stabilize; provide treatment; provide competency restoration training and evaluation as appropriate; provide rehabilitation and enrichment services; and prepare the person for a successful return to the community. In addition, the facilities will notify the resident’s Community Representative when the resident is actively seeking community placement or has been placed on a Pre-Discharge List; if the resident’s status changes; or, if the resident is subsequently removed from seeking placement or a Pre-Discharge List.

   b. Recovery Teams. It is the responsibility of the recovery teams to conduct initial observations and assessments and, in conjunction with the development of the recovery plan, develop a plan of expected services and supports needed upon discharge. The recovery team will update and revise the discharge plan as necessary and provide necessary documentation to potential service providers. These responsibilities will be completed in collaboration with the Community Representative.

   c. Community Representative. It is the responsibility of the Community Representative to participate in the development of the discharge plan and identify services and supports needed for the resident’s return to the community. The Community Representative will research resources for needs identified by the recovery team, participate in the discharge planning meeting, secure community placement and services in cooperation with state treatment facility social worker/discharge planner, maintain contact with the facility discharge planner and Social Worker, and ensure recommended services are received after the individual’s discharge.

   d. Circuits/Regions. It is the responsibility of the Managing Entity or other contracted provider to ensure the individual’s continuity of care. The Managing Entity or other contracted provider will develop needed services/supports not readily available to persons preparing for discharge from the state mental health treatment facilities and monitor provision of all recommended services upon discharge through designated case management providers.


   a. The facility will provide notification to the Social Security Administration when a resident who has been receiving social security benefits has been admitted.

   b. Discharge Planning is a process which:

      (1) Begins at the time of admission and continues throughout the duration of the hospitalization.

      (2) Specifies the supports and services a person will need and want when returning to the community and informs the Recovery Team regarding actions to be taken to address these needs and wants including:

         (a) Verification that the resident has sufficient identifying documents to support application for benefits and/or state issued identification card including as appropriate: birth certificate, marriage certificate(s), driver’s license, current passport, social security card, or U.S. Military issued photo-ID;

         (b) Verification that persons returning to the community are eligible for reinstatement of pay status upon discharge. Evidence of this verification and the eligibility shall be provided to the community representative/ME;

         (c) Assistance in developing a social support system in the community;
(d) Preparation for employment upon discharge if appropriate; and,

(e) Preparing the person to take as much responsibility as possible for addressing the person’s medical and psychiatric needs upon discharge.

(f) Determine need for guardianship as outlined in CFOP 155-58; Guidelines for Assisting State Mental Health Treatment Facility Residents Who May Benefit from Appointment of Public Guardianship.

(3) Allows the resident to make an informed choice for placement and services if not mandated by the Court.

(4) Includes determination as to whether the resident is under a criminal charge or court hold, and notification of the appropriate law enforcement agency of the resident’s expected discharge date if the resident is under a criminal charge, to facilitate transfer of custody of the resident to the appropriate law enforcement officer upon discharge.

(5) Requires participation of the following people:

(a) Resident and/or legal guardian;
(b) Recovery/treatment team members; and,
(c) Community Representative.

c. **Discharge Criteria.**

(1) Discharge criteria for residents committed pursuant to Chapter 394, F.S., are met when the Recovery Team determines that the resident’s psychiatric condition has improved so that the resident no longer:

(a) Is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services; and,

(b) Is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and,

(c) Is likely to inflict serious bodily harm to him/herself or another person in the near future, as evidenced by recent behavior causing, attempting, or threatening such harm, as specified in Chapter 394, F.S.

(2) Residents committed pursuant to Chapter 916, F.S., will be discharge ready when the Recovery Team determines the following conditions are met:

(a) Residents committed as Incompetent to Proceed:

1. Are considered competent to proceed (these individuals will be returned to the Court; procedures related to these residents will be governed by CFOP 155-22.); or,

2. Are considered capable of surviving alone or with the help of willing and responsible family or friends, including available alternative services and with treatment are not likely to suffer from neglect or refusal to care for themselves; and,
3. Are considered unlikely in the near future to inflict serious bodily harm to themselves or another person, as a result of their mental illness.

(b) Residents committed as Not Guilty by Reason of Insanity:

1. Are no longer considered manifestly dangerous to themselves or others as a result of their mental illness; and,

2. An appropriate plan for outpatient services has been developed including provisions for residential care and supervision, outpatient mental health and substance abuse services, and auxiliary services such as vocational training, educational services or special medical care needs.

(3) The discharge criteria for residents committed pursuant to Chapter 394, F.S., as a result of Mosher vs. State, 876 So.2d 1230 (Fla. 1st DCA 2004) are outlined in CFOP 155-13.

d. Discharging Voluntary Residents Committed Pursuant To Chapter 394, F.S.

(1) A facility will discharge a voluntary resident who has sufficiently improved so that placement in the facility is no longer desirable or when a voluntary resident revokes consent to admission or requests discharge.

(a) A voluntary resident who revokes consent to admission or requests discharge will be evaluated to determine if the resident meets criteria for involuntary commitment. Discharge planning will continue when involuntary commitment is not warranted based upon evaluation outcomes.

(b) A voluntary resident or relative, friend or attorney of the resident may request discharge either orally or in writing at any time following admission to the facility.

(c) The resident must be discharged within 24 hours of the request, unless the request is rescinded or the resident is changed to involuntary status pursuant to Chapter 394, F.S. The 24-hour time-period may be extended by the facility when necessary for adequate discharge planning, but will not exceed three working days.

(d) The request will be documented in the resident’s clinical record.

(e) Express and informed consent must be obtained if a person other than the resident makes the request for discharge.

(2) Recovery teams will develop individual treatment interventions to address voluntary persons who refuse discharge.

e. Discharging Involuntary Residents Committed Pursuant To Chapter 394, F.S.

(1) At anytime a resident is found to no longer meet the criteria for involuntary placement, the administrator shall:

(a) Discharge the resident, unless he/she is under court hold or criminal charge; or,
(b) Transfer the resident to voluntary status, unless he/she is under criminal charge or adjudicated incapacitated:

1. Before the transfer to voluntary status is processed, the mandatory initial involuntary examination must have been performed by a physician or clinical psychologist, and a certification of the person’s competence to provide express and informed consent to treatment must be completed by a physician;

2. Such a transfer is contingent on the person meeting the criteria for voluntary status, which should be documented by an Application for Voluntary Admission (form CF-MH 3098, available in DCF Forms) and a Certification of Person’s Competence to Provide Express and Informed Consent (form CF-MH 3104, available in DCF Forms); and,

3. When transfer to voluntary status occurs, notice must be provided to the person, the person’s guardian advocate, attorney, and representative.

(2) The facility administrator or designee shall provide prompt written notice of the discharge of an involuntary resident in the form of CF-MH 3038, “Notice of Release or Discharge” (available in DCF Forms), to the resident, guardian, guardian advocate, representative, initiating professional, Community Representative, and circuit court, with a copy retained in the resident’s clinical record.

f. Discharging Residents Committed Pursuant To Chapter 916, F.S. The facility administrator or designee shall provide prompt written notice of the discharge of an involuntary resident in the form of CF-MH 3038, “Notice of Release or Discharge” (available in DCF Forms), to the resident, guardian, guardian advocate, representative, initiating professional, Community Representative, and circuit court, with a copy retained in the resident’s clinical record. Recommendations to the committing Court for discharge of residents committed as Incompetent to Proceed or Not Guilty by Reason of Insanity due to mental illness served in a civil facility will be governed by the procedures set forth herein, as well as by the provisions of CFOP 155-18 and CFOP 155-22.

g. Discharging Residents with a Previous Commitment Pursuant To Chapter 916, F.S. Residents with a previous commitment pursuant to Chapter 916, F.S., who had their charges dismissed may require a 30-day notification to the state attorney prior to discharge, if required in the order of dismissal. Commitment orders will be reviewed for court notification requirements during initial discharge planning.

h. Dismissal of Charges for Individuals Remaining Incompetent to Proceed for Five Continuous Years, Pursuant to Chapter 916, F.S. CFOP 155-13 outlines the process to notify the Court when an individual is approaching five years as Incompetent to Proceed. Per section 916.145, F.S., the charges against the individual shall be dismissed without prejudice to the state if the defendant remains Incompetent to Proceed five years after such determination, unless the Court in its order specifies its reasons for believing that the defendant will become competent to proceed within the foreseeable future and specifies the time within which the defendant is expected to become competent to proceed. Individuals remaining incompetent to proceed for five years should be discharged from the state mental health treatment facility when picked up for transport to jail to await a hearing.

7. General Procedures.

a. The Community Representative will be involved in discharge planning as specified in CFOP 155-18 and CFOP 155-22 for individuals committed pursuant to Chapter 916, F.S.

b. The recovery team will develop a recovery plan within 30 days of admission. The recovery plan addresses discharge barriers, discharge criteria and specific resident-centered goals and
objectives related to community placement as well as other clinical, rehabilitative and enrichment interventions. The recovery plan includes input from the resident, Community Representative, family, guardian and others as appropriate.

c. The LOCUS is administered for all residents committed pursuant to Chapter 394, F.S. (Baker Act), and all residents committed pursuant to Chapter 916, F.S., as Not Guilty by Reason of Insanity. The LOCUS is completed using input from the resident’s recovery team. The most recent administration of the LOCUS should identify living environment needs and level of services upon discharge.

d. The recovery team maintains regular and ongoing reviews of the resident's readiness for discharge and updates the plan as necessary. The Community Representative and the ME are informed regarding resident discharge status.

e. Seeking Placement List.

(1) The purpose of the Seeking Placement List (SPL) process is to facilitate an effective, efficient and individualized method to discharge from the state mental health treatment facilities (SMHTFs) persons returning to the community. The list includes both civil (Chapter 394, F.S.) and forensic (Chapter 916, F.S.) individuals who plan to return to the community.

(2) The SPL process is as follows:

(a) The Recovery Team determines the resident is likely to be “Discharge Ready” within the next three (3) months.

(b) The Resident’s Recovery Team or assigned Facility Staff:

1. Completes the Discharge Ready Checklist to identify facility barriers for discharge. If the facility barriers are not resolved, the resident’s name should go on the Pre-Discharge List. If facility barriers have all been resolved, the resident’s name should go on the Seeking Placement List.

2. Notifies the Community Representative within five (5) days of the resident being placed on the Pre-Discharge Ready List.

3. Notifies the Community Representative via email on the same day the resident is placed on the SPL and includes that documentation in the resident’s SMHTF individual record.

4. Conducts the Discharge Planning Meeting with the Community Representative within thirty (30) days of the resident’s placement on the Pre-Discharge Ready List and completes the Transition Plan with the resident and the Community Representative.

5. For residents on the pre-discharge list, the assigned facility staff will update the Discharge Ready Checklist for those on their caseload every thirty (30) days, documenting the progress toward the facility barriers, and submit to their supervisor for review, approval and signature.

6. Designated facility staff shall review and compile the Facility’s Seeking Placement List and Pre-Discharge List and submit the updated lists to the Continuity of Care Liaison in the Program Office by the 10th of each month.
7. Facility staff shall send the Seeking Placement List and Pre-Discharge List of residents to each respective Managing Entity by the 10th of each month.

(c). The Community Representative and other Community Contacts:

1. Locates community housing and community services to address the resident’s needs and address potential community barriers within twenty (20) days.

2. If a resident does not have housing and community services arranged within 20 days of being placed on the SPL, the Community Representative shall submit the Community Barriers Checklist to the assigned facility staff by the last day of the month and/or individually throughout the month whenever a resident’s housing and services are not secured within the twenty (20) day timeframe.

(d). The Department’s Facility Headquarters staff will:

1. Compile the SPL data;

2. Monitor and track statewide performance on admission and discharge of individuals served in civil and forensic SMHTFs;

3. Disseminate data to the Department’s Substance Abuse and Mental Health (SAMH) regional staff, Managing Entities, SMHTF staff and other stakeholders; and,

4. Work in collaboration with Mental Health Treatment Facilities, SAMH Regions and Managing Entities to make data driven decisions to improve the admission and discharge process.

f. During the community discharge planning process, the resident’s recovery team or designated state mental health treatment facility staff will:

(1) Review the current commitment order to verify all court notice requirements are met;

(2) Assist the resident in obtaining financial resources as necessary for funding community placement and services prior to discharge; assist in the initial application for benefits and disability determination and verify that persons returning to the community are eligible for reinstatement of pay status upon discharge. The Benefits Coordinator should be consulted if there are barriers to benefits reinstatement;

(3) Verify that the resident has sufficient identifying documents to support application for benefits and/or state issued identification card including as appropriate birth certificate, marriage certificate(s), driver’s license, current passport, social security card, or U.S. military issued photo-ID;

(4) Assist the resident and Community Representative in locating appropriate community placement and services by arranging site visits, and preparing and submitting referral packets to the Community Representative;

(5) Coordinate the documentation and paperwork necessary for acceptance into community placement/services;

(6) Coordinate the completion of the State Mental Health Facility Discharge (form CF-MH 7001) in conjunction with the recovery team and submit the completed form 7001 to the Community Representative prior to discharge;
(7) Provide the Community Representative with at least seven days' notice of the anticipated discharge date whenever possible, or three days' notice when a resident is court ordered or is voluntary and requests discharge;

(8) In collaboration with the Community Representative, assist in developing a social support system in the community for the resident, prepare resident for employment upon discharge, if appropriate help prepare resident to take as much responsibility as possible for addressing their medical and psychiatric needs upon discharge; and;

(9) If the resident is under a criminal charge at the time of discharge, the administrator shall transfer the resident to the custody of the appropriate law enforcement officer upon discharge.

g. The Community Representative/Case Manager will:

(1) Participate in recovery team meetings when possible to anticipate and remedy possible barriers to community placement/services during discharge planning;

(2) Participate in the discharge planning meeting and assist in the development of a discharge or conditional release plan which addresses the needs of the resident in the community. The purpose of this meeting is to initiate activities and planning which will result in the provision of community services which will most appropriately address the resident's needs upon discharge, and:

(a) Assure a common understanding of the resident’s clinical conditions;

(b) Assure a common understanding of needed services and supports for discharge;

(c) Identify any other necessary information; and,

(d) Agree on responsibility for obtaining the necessary information.

(3) Secure placement and needed services and supports;

(4) Notify the mental health treatment facility once placement and services have been secure;

(5) Work to ensure possession of current and valid identification cards and retain copies of those documents in the individual’s community files to facilitate access to benefits upon return to the community.

h. Once an appropriate placement and all identified necessary services have been secured and, for residents committed pursuant to Chapter 916, F.S., a signed conditional release order has been obtained, the resident will be scheduled for discharge.

i. On the day of discharge, the referring physician or in absence of the physician, the designated charge nurse, will complete form CF-MH 7002 (Physician to Physician Transfer, available in DCF Forms). The completed form will accompany the resident and be given to the aftercare provider or entity responsible for dispensing or administering medications.

j. In instances where discharge planning is impeded or prevented due to lack of financial resources, community resources, legal barriers, inability to reach consensus, or any other barrier, the facility administrator/designee will be notified immediately. If matters are unable to be resolved in a timely manner, the facility will notify the Substance Abuse and Mental Health Program Office for resolution.
k. A copy of the discharge or conditional release plan will be placed in the resident’s clinical record. The discharge plan will address the following issues to meet the resident’s needs:

1. Financial resources;
2. Employment and education;
3. Physical and mental health;
4. Living environment;
5. Self-care capabilities;
6. Relationships (i.e., family/guardian, significant other);
7. Legal status and Competency Restoration Services (as appropriate);
8. Special needs;
9. Transportation;
10. Aftercare and support services including medication management; and,
11. Leisure activities.

l. Documentation.

1. The following documents must be completed, distributed, and maintained in accordance with Rule 65E-5, F.A.C., and as part of the resident’s clinical record:
   a. Discharge Form – form CF-MH 7001 or equivalent;
   b. Notice of Release or Discharge – form CF-MH 3038 (for involuntary residents only); and,
   c. Physician to Physician Transfer Form – form CF-MH 7002 or equivalent.

2. Any other notifications, documents, or consents required in CFOP 155-18 and CFOP 155-22 will be completed, distributed, and maintained as described for individuals committed pursuant to Chapter 916, F.S.

3. A Circuit Transfer Request (form CF-MH 1072, available in DCF Forms) must be completed when a resident is being discharged outside of the resident’s home circuit.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

WENDY SCOTT
Director, State Mental Health Treatment Facilities, Policy and Programs
SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

In paragraph 2, removed reference to Rule 65E-15, F.A.C., as this rule has been repealed; added definition of “Benefits Coordinator” (paragraph 4a); in paragraph 4b, changed “Community Case Manager” to “Community Representative” and revised definition; added definition of “Discharge Ready” (paragraph 4g); added definition of “Pre-Discharge Ready” (paragraph 4q); changed all references to community case manager, community liaison, FACT Team leaders/case managers, forensic specialist, forensic case manager, and any other community staff to “Community Representative”; added paragraph 6b(2)(f) regarding determination of need for public guardian; added requirement that the LOCUS assessment tool be used to identify living environment and needs upon discharge (paragraph 7c); consolidated Facility staff, Regional staff and Community Partners’ roles and responsibilities and added to new paragraph 7d, the new Seeking Placement List process; clarified the requirement for the use of the Physician to Physician Transfer, form CF-MH 7002, at discharge (paragraph 7i); and, added paragraph 7l(3) requiring that a Circuit Transfer Request (form CF-MH 1072) be completed when a resident is being discharged outside the resident’s home circuit.