MODEL DISCHARGE PLAN

(Reference: Minn. Stat.641.155)

CLIENT INFORMATION	
Name:	
Jail:	
Plan Type(s): ☐ **Medical** ☐ **Mental Health** ☐ **Substance Abuse** ☐ **Homelessness** ☐ **Employment**	
DOB:	**Confinement Release Date:**
Release Type/Status:	
Release Planner Contact Information: Name: Phone number: Email address:	

IMMEDIATE RELEASE PLAN	
Probation Officer Information:	
Social Worker Information:	
Housing Placement:	
Transportation Upon Release:	

LEGAL SUMMARY/CASE STATUS	
Future Court Date:	
Future Probation Officer check in Date:	
HEALTH CARE NEEDS	
Medical Provider(s):	Do you have a clinic in the community that you typically go to? ☐ Yes ☐No Do you receive any specialty services? ☐ Yes ☐No Do you prefer a male or female? Time of day?
Adaptive Devices:	Are you using any medical equipment? ☐ Yes ☐No

	Supply store?
Dental Provider(s):	To find a dental provider that will accept your health care plan, please contact the following: Minnesota State Assistance Telephone Line Phone: (651) 431-2670
Mental Health Provider(s):	Do you have a clinic or provider in the community that you plan to return to? ☐ Yes ☐No If so, please give as much information as you can. Are there any mental health services that you are interested in seeking in the community? ☐ Yes ☐No
Community Case Manager and/or ARMHS:	Have you had a community (mental health) case manager in the past? ☐ Yes ☐No Who & Where? Have you had an ARMHS worker in the past? ☐ Yes ☐No Who & Where? Would you like to be referred to: ☐ ARMHS ☐County ☐Both
Substance Use/Abuse Issues to be addressed:	Comprehensive Assessment Completed: (Formerly Rule 25): ☐ Yes ☐No
Treatment Program:	Have you been recommended to receive mental health services? ☐ Yes ☐No Have you been recommended to complete substance abuse treatment? ☐ Yes ☐No Do you have a sponsor? ☐ AA ☐NA

CLIENT NAME:

	Have you been referred to complete sex offender treatment services? ☐ Yes ☐No
Pharmacy:	When you leave , you should be given a - day supply of medication. You will also receive a prescription for a refill for a 30-day supply of all medications. Should you run out of medication before you are seen by a provider, you can take this prescription to any pharmacy for the refill as long as your medical insurance is active.
Additional Information:	

FINANCIAL NEEDS & HEALTH CARE COVERAGE	
Health Insurance:	Do you have health insurance? ☐ Yes ☐No Your Medical Assistance (MA) application was faxed to County on **(date)**. Your MA will be open on your release date.
Financial Applications (CAF, SSA, etc.):	Have you received Social Security in the past: ☐ Yes ☐No Did you receive: ☐ SSI ☐SSDI ☐ Both ☐ Unknown Would you like to apply for Social Security benefits: ☐ Yes ☐No You may be eligible for additional cash and food support. If you have access to a computer once, you are released you can apply for these benefits online at: https://mnbenefits.mn.gov Once you apply, County will contact you to schedule a phone interview to determine eligibility.

CLIENT NAME:

Additional Information:	**INSERT LOCAL LIBRARY- For free internet usage** **Disability Hub MN 1-866-333-2466; Option #1** *Disability Hub MN is a free statewide resource network that helps you solve problems, navigate the system and plan for the future. Also offers online live chat.* **Senior Linkage Line 1-800-333-2433** *Provides long term care options counseling; health insurance counseling (Medicare Part A, B, C and D); prescription drug expense assistance; long term care partnership insurance; caregiver planning, support and training; forms assistance.* **Portico Healthnet 651-489-2273** *Provides MNSure enrollment assistance; health system navigation. Portico helps uninsured individuals and families access affordable coverage and care.*

COMMUNITY SUPPORT	
Transportation:	Do you have a valid driver's license? ☐ Yes ☐No Will you be using public transportation? ☐ Yes ☐No Do you know how to or feel comfortable using public transportation? ☐ Yes ☐No **With Medical Assistance (MA), you may be able to use MNET transportation (FREE) for all medical appointments. Call 1-866-467-1724 at least 3 days in advance with MA number and address of your appointment to schedule rides.** **Medical Transportation** If your medical assistance is provided by one of the following you may be able to receive transportation to/ from medical appointments: **Patients with disabilities:**

	Metro Mobility: 651-602-1111 **Blue Plus medical assistance patients**: 651-662-8648 or 1-866-340-8648 **HealthPartners medical assistance patients:** 952-883-7400 **Medical assistance patients:** 651-645-3982 or 1-866-467-1724 **Medica Provide-a-Ride:** 952-992-2292 or 1-800-855-2880 **Metropolitan Health Plan patients:** 612-337-7433 **UCare Minnesota patients:** 612-676-6830 or 1-800-864-2157 Add resource on who to contact to help obtain valid driver's license
Personal Needs (clothing, food, etc.):	List personal items you have in the community and who they are with (give names and relationship to you): Do/will you have enough money to buy what you need? ☐ Yes ☐No Who will help you afford the things you will need? Are you familiar with the area and know where to get things? ☐ Yes ☐No Where will you go to buy/find these things (thrift stores, food shelves)? Add resources like salvation army, local food drives, red cross etc…
Employment Resources:	Add resources from county they can reach out to help look for employment.
Vocational Rehabilitation/Education:	Add resources for local school districts and adult education.

CLIENT NAME:

Community Resources:	**United Way First Call for Help Dial: 211** **From cell phone:** 651-291-0211 Notes: Call for FREE resource information in your area. Resources re: housing, financial assistance, transportation, medical care, employment, social support, sobriety, education, mental health services, etc.
Veteran Services:	**Please Call 1-888-LinkVet (546-5838) for all Veteran-related questions.** **Hours of Operation** Mon-Fri: 7 a.m. to 8 p.m., CST Sat: 9 a.m. to 2:30 p.m., CST Sun: 11 a.m. to 4:30 p.m., CST Closed Holidays
Additional Information:	

SUPPORT TEAM MEMBERS	
Emergency Contact:	Who is your emergency contact? (name, relationship to you, and phone number)
Sponsor(s):	Do you have/need a sponsor? ☐ Yes ☐ No If yes, you can list your sponsor(s) here. If no, would you like help applying for a temporary sponsor before you return to the community? ☐ Yes ☐ No **Minnesota Warmline** Metro: (651) 288-0400 Toll Free: 877-404-3190. *Anonymous line that creates a safe environment for people who are working on recovery. The staff all have a lived experience with mental illness.* Text the Minnesota Warmline M-S 5pm to 10pm. Text "support" to 85511 to chat with a Certified Peer Specialist *standard text message rates apply **MN NA Helpline** Phone: 1-877-767-7676
Crisis Response Information/Resources:	**Crisis line info and/or local hospital** **National Suicide Prevention Life Line**

	Phone: 1-800-273-TALK (8255) **Statewide Crisis Connection Program** Phone: (612) 379-6363 or Toll Free: 1-866-379-6363 *Notes: 24 hours a day, 7 days a week crisis counseling and/or referral services* **Men's Line Crisis Connection** Phone: (866) 379-6367 or Toll Free: 1-866-379-6367 *Notes: 24-hour free, confidential help for men who need to talk, who are stressed, angry, down, depressed or feeling out of control.* **TXT4Life is a suicide prevention resource** for residents in Minnesota. We can help you with relationship issues, general mental health, and suicide. We are **free, confidential**, and **here for you 24/7/365**. **Text "Life" to 61222 to be connected to trained, compassionate counselors.**
Additional Information:	

HEALTH SERVICES INFORMATION

Diagnostic Information (medical, mental health, psychiatric, SUD, etc.):

Allergies:

Medication:	**Dosage:**	**Frequency:**
Medication:	**Dosage:**	**Frequency:**
Medication:	**Dosage:**	**Frequency:**

Continuum of Care Recommendations:

- Attend all medical appointments and follow doctor recommendations for your medical condition(s).
- Please take your medication as it has been prescribed to you. You have been given a 7 to 30 day supply of your medications and prescription. Please get your prescription filled when needed.

APPOINTMENT(S) SUMMARY

CLIENT NAME:

Client signature:	**Date:**
Release Planner signature:	**Date:**

Original: Mental Health file (if applicable)
Medical file (if applicable)
Treatment Program file (if applicable)

CC: Case Manager
Client
Probation Officer

CLIENT NAME:

NOTICE:

This notice accompanies a disclosure of information concerning a client who may have been in alcohol/drug abuse treatment. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Do not remove this notice from the attached records.

Information in this plan is subject to change.