

# Montana Mental Health Nursing Care Center Aftercare Plan

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Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Discharge Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Destination: \_\_\_\_\_ Social Security No: \_\_\_\_\_  
Phone No: \_\_\_\_\_

Montana Mental Health Nursing Care Center

Contact Person: \_\_\_\_\_ Phone No: 406-538-7451

Guardian:

Address: \_\_\_\_\_ Phone No: \_\_\_\_\_

Contact Person at New Address: No longer requires Psychiatric Nursing Home Level of Care provided by the Mt. Mental Health Nursing Care Center. No longer exhibiting significant behavior problems.

Release Plan:

Problem Areas

Strengths:

Montana Mental Health Nursing Care Center Recommendations for Care Plan:

Residents Attitude Towards Discharge:

Diagnosis: See Face sheet

Present Medications: See Transfer Sheet

Medical Problems: See Transfer sheet

Financial Statement:

Current Payee:

Income:

<i>Interested Agencies</i>	<i>Date Referred</i>	<i>Current Status</i>
Mental Health	_____	_____
Social Security	_____	_____
SSI	_____	_____
Medicaid	_____	_____
Other	_____	_____