

Montana Mental Health Nursing Care Center Aftercare Plan

Name: _____

Date: _____

Admission No: _____

Date of Birth: _____

Destination: _____

Social Security No: _____

Phone No: _____

Montana Mental Health Nursing Care Center
Contact Person: _____

Phone No: _____

Guardian: _____

Address: _____

Phone No: _____

Contact Person at New Address: _____

Release Plan: _____

Problem Areas: _____

Strengths: _____

Montana Mental Health Nursing Care Center Recommendations for Care Plan:

Residents Attitude Toward Discharge:

Diagnosis:

Present Medications:

Medical Problems:

Financial Statement: _____

Current Payee: _____

Income: _____

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