Notification of Discontinuance of Community Support Team

Fax Form to the Collaborative at: 866-928-7177

Agency: _____ **Name of Referred**: _____
Agency Location:_____ **Date of Birth**: _____
Agency FEIN:_____ **RIN #** _____
Team Name: _____

Male: ☐ **Female:** ☐

Admit Date to CST:_____

CST was discontinued on (date) _____

I. DISCONTINUATION CRITERIA (please check one)

☐ Person requests termination form CST and is stable
☐ Person has improved to the extent that CST is no longer needed and recovery goals have been met. (No medical necessity for CST – please attach transition plan)
☐ Person has moved out of the CST Teams' geographic area (provide linkage information to new CST Team or community service)
☐ Person has moved out of State (make attempts to link with other CST or community services)
☐ Person cannot be located, in spite of repeated efforts. (Describe efforts to locate and continue CST services such as number of failed contacts, time elapsed since last contact: lack of leads on whereabouts from the person's emergency contact list.)
☐ Person requests termination from CST despite the clinical recommendation of the team
☐ Person has been incarcerated
☐ Person is in need of hospitalization that may exceed 90 days
☐ Person is in need of nursing facility level of care that may exceed 90 days
☐ Deceased

II. DIAGNOSIS

DSM Diagnosis ***All 5 Axes must be completed***	**Diagnosis (Code)**	**Rank (Please rank diagnoses in Axes 1-3 in order of primacy)**
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V - Global Assessment of Functioning (GAF) or C-GAS	Highest Last Year:	Current:

Agency: _____ **Name of Referred**: _____

Date of Birth: _____ **RIN #** _____

III. LOCUS SCORE FOR ADULTS AT TIME OF DISCONTINUATION

Domain Scores: Risk of Harm: _____ **Recovery Environment - Environmental Stressors:** _____

Recovery Environment – Environmental Support: _____ **Functional Status:** _____

Co-morbidity: _____ **Recovery and Treatment History:** _____ **Acceptance and Engagement:** _____

LOCUS recommended level of care at time service is being discontinued **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

IV. OHIO SCALE FOR YOUTH AT TIME OF DISCONTINUATION:

Worker Ohio problem severity scale (0-100) _____

V. TRANSITION PLAN – If applicable (NARRATIVE) (Please write legibly.)

Clinical staff to contact with any questions (print) _____

Phone: (_____)_____ Fax Number: (_____)_____

Encrypted email address: _____