



**SUBSTANCE ABUSE PREVENTION AND CONTROL  
DISCHARGE FORM-RECOVERY BRIDGE HOUSING**

1. Today's Date:		2. Specify number of RBH days for this episode:	
<b>PATIENT INFORMATION</b>			
3. Name: (Last, First, Middle):		4. Date of Birth (MM/DD/YYYY):	5. Medi-Cal or MHLA Number:
6. Address:			
7. Phone Number:		Okay to Leave a Message?    Yes    No	8. Gender:
9. Admission Date:	10. Discharge Date:	11. Discharge Diagnosis:	
<b>RBH AGENCY</b>			
12. Agency Name:			
13. Address:			
14. Contact Person:			
15. Contact Person Phone Number:			
<b>DISCHARGE INFORMATION</b>			
16. Please explain the reason for discharge:			
17. Has the Patient Been Screened for Whole Person Care?    Yes    No If no, is the patient interested?			
18. Was the VI-SPDAT Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, please explain:			
19. Was a housing referral placed? <input type="checkbox"/> Yes <input type="checkbox"/> No    Please explain:			
20. Is the patient continuing in SUD treatment following discharge from RBH? <input type="checkbox"/> Yes <input type="checkbox"/> No    Please explain:			
21. Staff Name:		22. Staff Signature:	
This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to APPLICABLE Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.			

**EXTERNAL SAPC REVIEW** *This section will include communication between SAPC and the agency/provider.*

Comments:

Assigned Staff: \_\_\_\_\_ Reviewed by: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INTERNAL SAPC USE ONLY** *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: \_\_\_\_\_ Reviewed by: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RECOVERY BRIDGE HOUSING DISCHARGE FORM INSTRUCTIONS**

*The discharge plan shall be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the patient.*

1. Enter today's date.
2. Enter the number of days the patient was in RBH for this particular episode.

**PATIENT INFORMATION**

3. Enter the patient last name, first name, middle initial.
4. Enter the patient date of birth.
5. Enter the patient Medi-Cal or My Health LA (MHLA) number.
6. Enter the patient address.
7. Enter the patient phone number and check the box if it is okay to leave a message.
8. Enter the patient gender.
9. Enter the admission date into Recovery Bridge Housing
10. Enter the discharge date
11. Enter the discharge diagnosis.

**RBH AGENCY**

12. Enter the RBH agency name.
13. Enter the RBH agency address.
14. Enter the name of the contact person at the RBH agency.
15. Enter the phone number of the contact person.

**DISCHARGE INFORMATION**

16. Please explain the reason for discharge
17. Check yes or no if the patient has been screened for Whole Person Care (WPC)? If no, is the patient interested? WPC-LA is a Medi-Cal 2020 waiver-funded program that will provide comprehensive and coordinated services to the sickest, most vulnerable LA County Medi-Cal beneficiaries such as individuals who are homeless, justice-involved, or have serious mental illness or severe and/or persistent substance use disorder or medical issues.
18. Was the VI-SPDAT completed? Check yes or no. If no, please explain.
19. Was a housing referral placed? Check yes or no, and explain whether or not a housing referral was placed.
20. Is the Patient Continuing in SUD Treatment? If yes, specify the provider and Level of Care:
21. Enter the staff name.
22. Enter the staff signature.

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**SUBMIT THE FORM TO:** Fax: (323)-725-2045  
Phone: (626)-299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE: <http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm>