

INTENSIVE CASE MANAGEMENT (ICM) DISCHARGE FORM

Admission Date: ___/___/___

Discharge Date: ___/___/___

Client Name: _____

Client Address: _____

SCA of transfer: _____

Phone: _____

Case Manager: _____

Date of Last Contact: ___/___/___

Reason for Discharge: (Please Check One)

- | | |
|---|---|
| <input type="checkbox"/> Completed ICM | <input type="checkbox"/> Institutionalized/Incarcerated |
| <input type="checkbox"/> Voluntary Discharge | <input type="checkbox"/> Transfer (<i>identify new address and SCA above</i>) |
| <input type="checkbox"/> Administrative Discharge | <input type="checkbox"/> Other (please specify) _____ |

Attainment of Service Plan Goals by Domain

Domain	Level of Self Sufficiency Based on last administered ISS
Housing	
Child Care	
Educational/ Vocational Services	
Employment Services	
Basic Needs	
Transportation	
AODT Treatment	
Legal Services	
Mental Health	
Physical Health	
Family/Social	
Life Skills	

Case Manager's Signature

Date

Supervisor's Signature

Date