_____DEVELOPMENTAL CENTER

Discharge Checklist

Name of Individual: _____ Date: _____

The provider has received a copy of the following:

Individual Program Plan (IPP) _____
(including Transition Plan and Behavior Support Strategies as applicable)

Special Team Meeting Minutes _____

Essential Healthy Lifestyle Plan
(including list of current medications) _____

Pre-Discharge Meeting Minutes _____

Continued Review after Discharge _____

Current Assessments (as applicable)

- Psychological Assessment _____
- Social Services/History _____
- Physical Examination _____
- Nutritional Assessment _____
- O.T. Assessment _____
- P.T. Assessment _____
- Speech Assessment _____
- Vocational Assessment _____
- Psychiatric Assessment _____
- Other_____ _____
- Other_____ _____

Discharge Inventory _____

Other: _____ SS Card; ____ Medicare Card; _____ Rx Card; ____ Medicaid Card; _____ Guardianship Papers; _____ Birth Certificate; ____ Burial/Funeral Plans

I have received a copy of the above and will contact _____ if any further information is needed.

_____ _____

New Provider/Representative **Date**

_____ _____

DC Staff **Date Completed**

Updated 3/26/15