DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health
1901 North DuPont Highway, New Castle, Delaware 19720

Community & Hospital Coordinated Care Form

Section 1: Client Information

Client Name:	Unit:	Date:
Hospital Social Worker:	In-Patient Facility:	
Admission Date:	Anticipated Date of Discharge (Provider):	Community Supports/Guardian/Family Info: _____ _____ _____ _____
Anticipated Date of Stability (Hospital):	Reason(s) for ADOD Extension(if applicable): _____ _____	

Section 2: Provider Information

Is this the first time a representative from your agency has met with this client during this admission period?
Circle: Y / N If **NO**, when did your agency make the first contact? **Date:**_____

Provider Agency Rep:	Agency:
Program:	Phone:

Purpose of Contact (circle all that apply): Treatment Team / On-Site Visit / Community Pass / Other:_____

Instructions: If **Treatment Team** Circled: Complete Section **3** and **sign first page.**
If **On-Site Visit** Circled: Complete Sections **4 and 7** and **sign second page.**
If **Community Pass** Circled: Complete Sections **5, 6 and 7** and **sign second page.**
If **Other** Circled: Complete Sections **4 and 7** and **sign second page.**

Section 3: Treatment Team Information

Please complete this section if you circled "Treatment Team" under Purpose of Contact

Critical Tasks	Issues / Actions / Date(s)	Responsible Party
Doc - to – Doc Contact: Upon Admission or at Referral		
Doc - to – Doc Contact: Day before Discharge		
Federally Compliant Delaware Photo ID:		
Housing Plan: (refer to Community Living Questionnaire)		
Medical Concerns:		
Clinical/Treatment Status:		
Benefits:		
Peer Support:		
Legal:		
Other:		

PRINT NAME	Title/Credentials	SIGNATURE
Client:		
Provider Staff:		
Hospital Staff:		

Client Name:_____ TIME IN ____:____ AM/PM TIME OUT ___:___AM/PM

Section 4: On-Site Visit Information - Complete this section if ON-SITE VISIT or OTHER was purpose of contact.
☐ **Check box if client declined visit (briefly describe why)**
Purpose:
Outcome:
Plan:
Section 5: Pass Information - Complete this section if COMMUNITY PASS was purpose of contact.
Briefly describe where you went and what you did. What did you and the client discuss?
Date of next planned visit:
Section 6: Pass Issues (if applicable)
Yes / No (If Yes, name of notified staff and briefly describe the issue)
Section 7: Needs/Other Notes - Complete this section if ON-SITE VISIT, COMMUNITY PASS or OTHER was purpose of contact
What do you need from the Treatment Team in order to follow up on your discussion with the client?

Provider Signature/Credentials:	**Date:**

For all client interactions, Community Service Providers must complete this form and submit it to admissions when signing out