St. Clair County Community Mental Health Authority

Program Placement/Transfer Meeting

Date:_____

Individual:_____ Case #:_____

Program/Residence:_____

Start Time:_____ Stop Time:_____

I. PURPOSE OF MEETING (include name of receiving transfer program(s); if this is placement of a child, complete #041-B instead):

II. INDIVIDUAL SATISFACTION (indicate individual satisfaction with current program(s)' services to date):

III. STATUS REPORT:

A. Progress To-Date (indicate, by brief summary, current progress or lack thereof which led to transfer):

B. New Prioritized Treatment Needs:

IV. EXPECTATIONS (indicate what individual expects to achieve, use quotes if possible):

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EHR: Services, Placement/Transfers

V. GROUP DISCUSSION (include exchanges of significant information; please address individual's strengths, abilities and preferences):

VI. FUTURE/FOLLOW-UP ACTIVITIES:

A. Timeframes:

1. Visitation Scheduled: ☐YES ☐NO; Date/Time:_____

2. Home Placement Date:_____ ☐N/A

3. Program/School Start Date:_____ ☐N/A

4. Short-Term Service Timeframe:_____

B. Transfer Checklist: This checklist may be completed and affixed by the current and new primary caseholders.

_____	_____	_____
Case Holder Signature/Credentials	Print Name	Date

Other Signatures:

_____	_____
_____	_____
_____	_____

☐ Individual Received Copy

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