CRISIS & TRANSITION PROGRAMS

CYCLE OF SUPPORT

1. Referral & Screening

A person is identified as needing crisis services and is referred by their county, provider, or family.

RCC reviews the person's needs to ensure they are a good fit for the services.

2. Intake

RCC welcomes the person, completes necessary paperwork, and introduces the person to staff and program routines.

This builds comfort and sets the foundation for care.

3. 45-Day

A thorough review of strengths, needs, and risks is completed.

This assessment guides individualized supports and programming.

4. Goals & Programming

Person-centered goals are created, and structured supports are put in place.

This provides direction and a plan for growth and stability.

5. Bi-Weekly Meetings

Staff, family, and case managers meet regularly to review progress.

Adjustments in programming may occur to ensure goals remain effective and achievable.

6. Stabilization

Through consistent support and routine, the person builds skills & reduces crisis behaviors.

There is a focus on safety, progress, and skill-building.

7. Transition Planning

Planning begins for the person's next step, whether returning home, independent living, or another supportive setting.

RCC completes a Transition Plan that is shared with the person's next step.

8. Discharge

The person transitions out of crisis or transition with resources and connections in place.

Follow-up ensures continuity and ongoing support.

RCC RUDOLPH COMMUNITY AND CARE

RCC Proprietary