BEHAVIORAL HEALTH
CLINICAL DISCHARGE NOTIFICATION FORM

Submit completed form within one business day: *MCO EMAIL/FAX #*

Date Form Completed:

FACILITY INFORMATION

Name of Facility:
Out of State Facility (Y/N):
National Provider ID:
Address/Service Location:
Facility/Program Contact (Name):
Phone:
Fax:

MEMBER INFORMATION

**Please complete applicable fields.*

Member Name (First/Last):
Member ID or SSN:
Member DOB:
Member Age:
Name of Legal Guardian:
Guardian Address:
Guardian Phone:
Consumer's currently lives with (homeless, parents/siblings):
Is the member involved with CYFD-CPS (Yes/No)?
Is the member currently in custody of CYFD (Yes/No)?
If yes, CYFD SW Name/Phone:
Is the member involved with Adult Protective Services?

If yes, APS SW Name/Phone:

Is member involved with CYFD Juveniles Justice Services (JJS) (Y/N)?

If yes, JJS Name/ Phone:

Power of Attorney (POA) Name/Phone:

Treatment Guardian Name/Phone:

DD Waiver Status:

DISCHARGE INFORMATION

Level of Care Discharging from:

Start Date of Treatment/Admission:

Date/Time of Actual Discharge:

Total Length of Stay:

Reason for discharge (describe if planned discharge/treatment completed, needs higher LOC, left AMA, elopement, Other):

Mental Status upon Discharge:

Member discharged to (Address/Phone Number):

If member is DC to an out of home placement/ LOC:

Agency name

Agency Contact:

Primary Care Provider (PCP) notified of discharge Yes/No?

If no, why not?

PCP name and contact information:

School notified of discharge Yes/No/NA?

If no, why not?

Probation notified of discharge Yes/No/NA?

If No, why not?

DSM DIAGNOSES UPON DISCHARGE

DSM Diagnosis (Include DSM codes):

Description of Medical Needs (Including DME and chronic/co-morbid conditions):

DISCHARGE MEDICATIONS

(List all MH/SA and Medical)

Name:

Dosage:

Frequency Taken:

Date Started:

Prescriber:

Is member adherent to medication (Yes/No)?

If no, why not?

Response to medication:

Who will monitor medications after discharge?

AFTERCARE PLAN

**Please make an effort to schedule Follow-Up Behavioral Health Appointments within seven (7) days of discharge per Healthcare Effectivness Data and Invormation Set (HEDIS) measure requirements.

List scheduled appointments: (include appointment dates and times, contact information for provider):

Barriers to successful implementation of aftercare plan?

Referred to Core Service Agency (CSA) Yes/No?

CSA name:

Additional comments/notes: