Montana Medicaid Youth Discharge Notification Form  
Notice of Discharge from Services

Please type or print clearly. Processing may be delayed if information submitted is illegible or incomplete.

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| Youth Information | | | | | | | | |
| Youth NAME: | | | | | | | | |
| Custody: | | Parent/Legal Guardian  Turned 18  Child and Family Services | | | Department of Corrections  Tribal  Other: | | | |
| ADDRESS: | | | CITY: | | | | STATE: | ZIP: |
| COUNTY: | | SSN: | DOB: | | | medicaid number: | | |
| Reason for Discharge: | No longer meets criteria – Higher LOC required  No longer meets criteria – Lower LOC required  No longer meets criteria – Aged out  Completed treatment  Ran away – Eloped | | | Parent/Guardian withdrawal  Youth cannot be managed in milieu  Current treatment not appropriate for diagnosis  Other: | | | | |

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| Responsible Party Information | | | | | | |
| Name: | | | | Phone Number: | | |
| ADDRESS: | | CITY: | | | STATE: | ZIP: |
| Relationship to Youth: | Parent/Legal Guardian  Child and Family Services  Tribal Social Services  BIA | | Youth Court  Youth Department of Corrections  Other: | | | |

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| Discharging Provider Information | | | | | |
| PROVIDER NAME: | | | | | |
| NPI Number: | | | TAXONOMY: | | |
| NAME OF PERSON SUBMITTING FORM: | | | | | PHONE NUMBER: |
| Discharged to: | Parent/Relative  Independent Living  Foster Home  Therapeutic Foster Home  Homeless Shelter/Shelter Care | | | Hospital Acute/Partial  In-state PRTF  TGH (Name:      )  Out-of-state PRTF  Jail/Correctional Facility  Other: | |
| name of contact upon discharge: | | | PHONE NUMBER: | | |
| TODAY’S DATE (mm/DD/CCYY): | | DATE OF ADMISSION (MM/DD/CCYY): | | | DATE OF DISCHARGE (MM/DD/CCYY): |