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:      |
| Relationshipto 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):      |