

**BEHAVIORAL HEALTH  
CLINICAL DISCHARGE NOTIFICATION FORM**

**Submit completed form within one business day:**

Email: BHRequests@Molinahealthcare.com

Fax: 505.924.8237 or 888.295.5494

**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:

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**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:

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### **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:

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?

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### **DSM DIAGNOSES UPON DISCHARGE**

DSM Diagnosis (Include DSM codes):

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

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### **DISCHARGE MEDICATIONS**

(List all MH/SA and Medical)

Name:

Dose:

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 7 days of discharge per 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: