

## HIGHER LEVEL OF CARE DISCHARGE TEMPLATE

ALL FIELDS WITH \* ARE REQUIRED

Provider EDS/CMAP ID # (Medicaid 9-digit ID): \_\_\_\_\_

Facility/Provider Name: \_\_\_\_\_ Contact # & Ext: \_\_\_\_\_

Facility/Provider Service Location: \_\_\_\_\_

Name of clinician who filled out this form: \_\_\_\_\_ Credentials/Title: \_\_\_\_\_

Member Name: \_\_\_\_\_

Medicaid/Consumer ID#: \_\_\_\_\_ DOB: \_\_\_\_\_ and/or SSN: \_\_\_\_\_

**LEVEL OF CARE:**     Inpatient             Partial Hospitalization             Freestanding Detox             Residential Rehab  
                                   PRTF                     Inpatient Detox                     SFIT                                     Adult Group Home

### QUESTIONS:

1. \* Actual Discharge date (EX: 09/01/2017): \_\_\_\_\_

2. \*Behavioral Diagnoses (*Primary is required*)

\*Diagnosis Code: \_\_\_\_\_ \*Description \_\_\_\_\_

\*Diagnostic Category: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_ Description \_\_\_\_\_

Diagnostic Category: \_\_\_\_\_

3. \*Primary Medical Diagnoses (*Primary is required or indicate "None" or "Unknown"*)

\*Diagnosis Code: \_\_\_\_\_ \*Description \_\_\_\_\_

\*Diagnostic Category: \_\_\_\_\_

4. \*Social Elements Impacting Diagnoses (*Required - Check all that apply*)

- None     Educational problems     Financial problems     Housing problems (Not Homelessness)
- Occupational problems     Other psychosocial and environmental problems \_\_\_\_\_
- Problems with access to health care services     Homelessness
- Problems related to interaction with legal system / crime     Problems with primary support group
- Problems related to social environment     Medical disabilities that impact diagnosis     Unknown

5. Functional Assessment (*Optional*)

- CDC- HRQOL     CGAS     FAST     GAF     OMFAQ     SF12     SF36     WHO DAS
- OTHER \_\_\_\_\_ ASSESSMENT SCORE \_\_\_\_\_

6. \*Discharge Condition Compared to Admittance (*Please check appropriate box.:*)

- Improved                     No Change                     Worse                     Unknown

7. \*Medication at Discharge with Dosage and Frequency (*Narrative*):

\_\_\_\_\_  
 \_\_\_\_\_

**CURRENT RISKS (Key):**

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

Please circle one of the following for each question below based on Current Risks Key above:

8. \*Member's risk to self? 0 1 2 3 N/A

Check all that apply: (\*Required if Risk is Moderate or Severe)

- Ideation  Intent  Plan  Means  Current Serious Attempts  Prior Serious Attempts  Prior Gestures

9. \*Member's risk to others? 0 1 2 3 N/A

Check all that apply: (\*Required if Risk is Moderate or Severe)

- Ideation  Intent  Plan  Means  Current Serious Attempts  Prior Serious Attempts  Prior Gestures

**10. CURRENT IMPAIRMENTS**

A. \*Mood Disturbances (Depression or Mania)

- 0  1  2  3  N/A

C.. \*Anxiety

- 0  1  2  3  N/A

D. \*Psychosis / Hallucinations / Delusions

- 0  1  2  3  N/A

F. \*Thinking/Cognitive/Memory/Concentration Problems

- 0  1  2  3  N/A

H. \*Impulsive/Reckless/Aggressive Behavior

- 0  1  2  3  N/A

J. \*Activities of Daily Living Problems

- 0  1  2  3  N/A

L. \*Impairments Related to Loss/Trauma

- 0  1  2  3  N/A

B. \*Weight Changes Associated with Behavioral Diagnosis

- 0  1  2  3  N/A

For 2 or 3 rating:

Weight  Gain  Loss  N/A

Past 3 Mos \_\_\_\_\_ Lbs  N/A

Current Wt \_\_\_\_\_ Lbs  N/A

Height \_\_\_\_\_ Ft \_\_\_\_\_ In  N/A

E. \*Medical / Physical Conditions

- 0  1  2  3  N/A

G. \*Substance Use /Dependence

- 0  1  2  3  N/A

For 2 or 3 rating, check all that apply:

- Alcohol Illegal  Drugs  Prescription Drugs

I. \*Job/School/Performance Problems

- 0  1  2  3  N/A

K. \*Social Functioning/Relationships/Marital/Family Problems

- 0  1  2  3  N/A

M. \*Legal

- 0  1  2  3  N/A

For 1, 2 or 3 rating: Check all that apply

- Juvenile Justice  Probation  Parole  Other Court

11. \*Type of Discharge

- Against Medical Advice (AMA)  Planned

12. \*Discharge plan in place?

- Yes  No

13. \*Actual Level of Care/Service Discharged To (Primary)

- Detox  Ambulatory Detox  Residential SA Rehab  ASD Services  IICAPS  MDFT  EDT  FFT  FST  MST  IPF  PHP  IOP  Outpatient  GH  Medical  Other non-Authorized Services  PRTF  RTC  VNA/Home Health  None - Left AMA  Other (Please Specify): \_\_\_\_\_

14. \*PCP Notified?  Yes  No  N/A

15. \*Actual Discharge Residence (Primary)

- AWOL  Correction Facility  Foster Home  Group Home Non Therapeutic  Group Home Pass  Group Home Therapeutic  Home  Independent Living  Juvenile Detention  Nursing Home/SNF/Assisted Living  PRTF Community  PRTF Solnit  RTC  State Hospital  Supervised/Supportive Housing  Therapeutic Foster Care  Transfer to Alternate Psych or Rehab Facility  Transfer to Medical  Unknown  Other (Please Specify): \_\_\_\_\_

16. **\*Is member being discharged from RTC, GH, PRTF?**

Yes  No

17. **\*If yes, reason for RTC, GH, or PRTF Discharge?**

- Age 18/signed self out  Aged out  AWOL  Court Ordered / Mandated  Fire Setting Risk
- Medically Compromised  Needs higher level of care  Parent/Caretaker removed child
- Psychiatrically decompensation  Ready for lower level of care  Run away history  Sexually inappropriate
- Too aggressive / assault  Too Low functioning

18. **Additional RTC, GH, or PRTF Discharge Information (Narrative)**

\_\_\_\_\_

19. **\*Person to Contact for Follow Up:** \_\_\_\_\_

**\*Relationship:**

- Attorney  Aunt/Uncle  Case Manager  Child  Child-In-Law  Cousin  Executer  Foster Parent
- Friend  Grandparent  Guardian  Legal Representative  Niece/Nephew  Other Relation  Parents-In-Law
- Parents  Provider/Facility  Self  Sibling  Sibling-In-Law  Sponsor  Spouse  Step-Child
- Step-Parent  Step-Sibling  Trustee  Unknown

**\*Phone #:** \_\_\_\_\_

20. **\*Does the discharge plan involve Member, Guardian and/or Parent participation?**

Yes  No  Unknown

21. **\*What CT BHP Services are needed?**

ICM  Peer Services  ICM & Peer Services  None

22. **Medical Aftercare (Narrative)**

\_\_\_\_\_

23. **Other Resources/Support Systems to be Utilized (Narrative)**

\_\_\_\_\_

24. **\*Primary Aftercare Behavioral Health Provider:**  Arranged  Not Arranged  Do Not Know  Member Refused

If an Aftercare Behavioral Health Provider is arranged, please answer the following:

Provider Name: \_\_\_\_\_

Provide Phone #: \_\_\_\_\_ Provider Licensure Level: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Scheduled Appointment Date: \_\_\_\_\_ Scheduled Appointment Time: \_\_\_\_\_

Member Requests Appointment Reminder:  Yes  No

Type of Appointment:  Mental Health  Substance Use  Medication Management

25. **Secondary Aftercare Behavioral Health Provider (Optional):**  Arranged  Not Arranged  Do Not Know  Member Refused

If a secondary Aftercare Behavioral Health Provider is arranged, please answer the following:

Provider Name: \_\_\_\_\_

Provide Phone #: \_\_\_\_\_ Provider Licensure Level: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Scheduled Appointment Date: \_\_\_\_\_ Scheduled Appointment Time: \_\_\_\_\_

Member Requests Appointment Reminder:  Yes  No

Type of Appointment:  Mental Health  Substance Use  Medication Management

26. \*Aftercare Prescribing Physician:  Arranged  Not Arranged  Do Not Know  Member Refused

If an Aftercare Prescribing Physician is arranged, please answer the following:

Provider Name: \_\_\_\_\_

Provide Phone #: \_\_\_\_\_

Type of Prescriber:  Behavioral Health MD  Clinical Nurse Specialist  Primary Care Physician – MD  
 Psychiatrist  Other (Please specify): \_\_\_\_\_

Scheduled Appointment Date: \_\_\_\_\_ Scheduled Appointment Time: \_\_\_\_\_

Member Requests Appointment Reminder:  Yes  No

27. Medical Care Physician (Optional)

Provider Name: \_\_\_\_\_

Provide Phone #: \_\_\_\_\_

Reason for Medical Physician Involvement:  Co-Morbid Medical Condition  Medication Management  
 Mental Health or Substance Use Follow Up  Routine Medical Care  Other (Please specify): \_\_\_\_\_

Scheduled Appointment Date: \_\_\_\_\_ Scheduled Appointment Time: \_\_\_\_\_

Member Requests Appointment Reminder:  Yes  No

28. Beacon Health Options Health Alert Preferences:

**NOTE:** Beacon Health Options Health Alert is a program that will send automated calls to members reminding them about their follow-up appointments. You **MUST** obtain the member's consent before utilizing this service and should only check "Yes" for *Member Requests Appointment Reminder* in the sections above once this consent is obtained. If member consent was obtained, please complete the fields below to detail how the member would like to receive their alert(s).

\*Contact Type  Self

\*First and Last Name \_\_\_\_\_

\*Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

\*Preferred Time of Day for Reminders

Morning (9am to Noon)  Afternoon (Noon to 5pm)  Evening (5pm to 8pm)

\*Time Zone

Alaska  Atlantic  Central  Eastern  Hawaii  Mountain  Pacific

\*Preferred Reminder Type

Phone  Email