Magellan HEALTHCARE SM

Therapeutic Leave Day Request Form
Fax to Magellan: 1.888.656.4916

Today's Date: _____

Therapeutic Leave Day Requirements:

1. Are requested by the Treatment Team and included in the treatment plan.
2. Are considered a treatment *intervention* with a safety plan.
3. Are documented in the medical record.
4. Have a sound clinical rationale.
5. Are limited to 14 overnights per treatment episode. Each overnight is 1 TLD.

Member Name: _____ Member Date of Birth: _____

Medicaid ID #: _____ Facility: _____ MIS #: _____

Current LOC: _____ Admit Date: _____ Estimated D/C Date: _____

TLD Contact Name: _____ Phone #: _____ Fax #: _____

Therapist: _____ Supervising Practitioner: _____

Caseworker: _____ # of TLD's the Member has had to date: _____

Date/NIGHT(S) for TLD you are requesting: _____

Please list the patient-specific clinical goals to be accomplished during this TLD: _____

_____

_____

Please describe how the TLD goals will be evaluated or measured: _____

_____

_____

Please describe how the TLD supports the discharge/permanency plan for this youth, including the number of family sessions and/or day passes the family has participated in:

_____

_____

_____