Magellan HEALTHCARE℠

Child/Adolescent Discharge Notification Form
Fax to Magellan: 1.888.656.4942

Client Information

Client Name: _____

Client Medicaid Number: _____

Facility Name: _____

Discharge Date: _____

Client Discharging to: (City) _____

Type of Discharge Placement

☐ Family Home ☐ ThGH ☐ Group Home ☐ PRFC
☐ Foster Home ☐ PRTF ☐ Inpatient Hospital ☐ Other:

Legal Guardian Information

Is Member a State Ward: ☐ Yes ☐ No

Legal Guardian Name: _____ *If State Ward, please list HHS Case Worker*

Legal Guardian Phone #: _____

Lead Agency/Probation Information

Lead Agency: ☐ NFC ☐ N/A
Lead Agency/Probation Contact Person Name: _____
Lead Agency/Probation Contact Phone #: _____

Follow-Up Appointment Information

Provider #1 - Name:	Provider #2 - Name:	Provider #3 - Name:
Phone #:	Phone #:	Phone #:
Type of Service: ☐ Outpatient ☐ Intensive Outpatient ☐ Medication Evaluation ☐ Partial Hospitalization ☐ Community Treatment Aid ☐ Detention ☐ Other :	Type of Service: ☐ Outpatient ☐ Intensive Outpatient ☐ Medication Evaluation ☐ Partial Hospitalization ☐ Community Treatment Aid ☐ Detention ☐ Other :	Type of Service: ☐ Outpatient ☐ Intensive Outpatient ☐ Medication Evaluation ☐ Partial Hospitalization ☐ Community Treatment Aid ☐ Detention ☐ Other :
Date/Time of First Appointment:	Date/Time of First Appointment:	Date/Time of First Appointment: