Magellan Behavioral Health of Pennsylvania Inc.
Family Based Services Discharge Form

Instructions: This form is used to communicate to Magellan when a member is being discharged from Family Based Services (FBS). Please complete this form within **3 business days** of discharge from FBS. The completed form should be faxed to the attention of the Family Based Team at **1-866-667-7744**. Business or clinical staff may complete this form.

Thorough discharge information increases Magellan's ability to monitor continuity of care, collect member focused outcome data, and is a requirement of the Family Based Services Value Based Purchasing Program incentives.

☐ Bucks County ☐ Cambria County ☐ Delaware County ☐ Lehigh County ☐ Montgomery County ☐ Northampton County

MEMBER INFORMATION

Member Name: _____

Medicaid ID #: _____ Date of Birth: _____

Mailing Address: _____

Phone #: _____

PROVIDER INFORMATION

Provider Name: _____

Provider MIS #: _____ Provider Tax ID #: _____

Provider Phone #: _____

Name and Credentials of Person Completing Form: _____

Position of Person Completing Form: _____

Phone # of Person Completing Form: _____

SERVICE INFORMATION

All Diagnoses at Discharge: (ICD-10 Format) _____

Discharge Date: _____

REASON FOR DISCHARGE (Check One)

☐ Treatment Completed/Resolution of Problem
☐ Transition of Care
☐ Member Declined Further Services
☐ Other: _____
☐ Discharged to Residential
☐ Transferred to Group Home
☐ Member Benefits Termed/Exhausted or No Longer Eligible

INDICATE LEVEL OF CARE TO WHICH MEMBER IS BEING DISCHARGED (Check One)

☐ Outpatient
☐ Outpatient Psychiatry
☐ Intensive Outpatient (MH)
☐ Intensive Outpatient (Substance Use)
☐ ICM
☐ CPS
☐ TIP
☐ ACT
☐ BHRS
☐ BHRS (ABA)
☐ MST
☐ Clozaril Monitoring
☐ Psych Rehab
☐ CRR HH
☐ Partial Hospitalization
☐ Acute inpatient
☐ RTF
☐ Other: _____

SERVICE(S) MEMBER REFERRED TO AT TIME OF DISCHARGE

1) Name of Person/Agency Providing Services after Discharge: _____
   Mailing Address: _____
   Phone #: _____
   Appointment Scheduled? ☐ Yes ☐ No If Yes, Date/Time of Apt Scheduled: _____
   If No Appointment Scheduled, List Reasons: _____

2) Name of Person/Agency Providing Services after Discharge: _____
   Mailing Address: _____
   Phone #: _____
   Appointment Scheduled? ☐ Yes ☐ No If Yes, Date/Time of Apt Scheduled: _____
   If No Appointment Scheduled, List Reasons: _____

3) Name of Person/Agency Providing Services after Discharge: _____
   Mailing Address: _____
   Phone #: _____
   Appointment Scheduled? ☐ Yes ☐ No If Yes, Date/Time of Apt Scheduled: _____
   If No Appointment Scheduled, List Reasons: _____

DISCHARGE MEDICATIONS – *List Psychotropic or Medical Medications Supplied*

Medication	Dose	Frequency	Amount Supplied

Recent Medication Changes: (Included dose/freq. changes) _____

PRIMARY CARE PHYSICIAN (PCP)

Does Member already have a PCP? ☐ Yes ☐ No If Yes, Name of PCP: _____
If No, has PCP been identified, to be linked at discharge? ☐ Yes ☐ No
If No PCP, Why? _____

RACE – *Self-Identified Race of Individual Receiving Services (Optional)*

☐ 01 Alaska Native
☐ 02 American Indian
☐ 03 Asian or Pacific Islander
☐ 04 Black or African American
☐ 05 White
☐ 06 Other
☐ 13 Asian
☐ 23 Native Hawaiian or other Pacific Islander
☐ 31 American Indian or Alaska Native and White
☐ 32 Asian and White
☐ 33 Black or African American and White
☐ 34 American Indian or Alaska Native and Black or African American
☐ 35 Other multi-race
☐ 97 Unknown (Asked but not Answered)
☐ 98 Not Collected (Not Asked)

ETHNICITY – *Hispanic Origin (Optional)*

- ☐ 01 Puerto Rican
- ☐ 02 Mexican
- ☐ 03 Cuban
- ☐ 04 Other Hispanic
- ☐ 05 Not of Hispanic Origin
- ☐ 06 Hispanic (Specific Origin not Identified)
- ☐ 97 Unknown (Asked but not Answered)
- ☐ 98 Not Collected (Not Asked)

SMI OR SED STATUS AT TIME OF DISCHARGE

- ☐ 01 None
- ☐ 11 Serious Mental Illness (SMI)
- ☐ 12 Serious Emotional Disturbance (SED)
- ☐ 13 At risk of SED
- ☐ 96 Not Applicable
- ☐ 97 Unknown (Asked but not Answered)
- ☐ 98 Not Collected (Not Asked)

EDUCATIONAL LEVEL AT TIME OF DISCHARGE

- ☐ 03 Preschool/Kindergarten
- ☐ 04 Some Elementary School (Grades 1-7)
- ☐ 05 Completed Elementary School (Grade 8)
- ☐ 06 Some High School or Vocational Education
- ☐ 07 Completed High School or Vocational Education

TYPE OF RESIDENCE AT TIME OF DISCHARGE

- ☐ 01 Private Residence or Household
- ☐ 04 Foster Home or Family Sponsor Home
- ☐ 07 Residential Treatment

ARRESTS

Number of Arrests within Past 30 Days: _____

SOCIAL CONNECTEDNESS WITH ACTIVITIES SUPPORTING/FOCUSING ON RECOVERY

- ☐ 01 No Participation within the Last Month
- ☐ 02 Participated 1-3 times within the Last Month
- ☐ 03 Participates 1-2 times per Week
- ☐ 04 Participates 3-6 times per Week
- ☐ 05 Participate Daily
- ☐ 96 Not Applicable
- ☐ 97 Unknown (Asked but not Answered)
- ☐ 98 Not Collected (Not Asked)

_____ _____

Signature of Person Who Completed Form | Date Form Completed