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DD Health Home Team

Discharge Form

The DD Health Home (DD HH) Discharge Form must be completed in full. Please complete the form, save a copy, and submit the form as an attachment using the **State of Missouri's Proofpoint system**. Include "DD HH Discharge" in the subject line (do not include additional information, especially PHI) and send to the DD Program Manager/DD HH Enrollment Coordinator at DDHHEnrollTransferDischarge@dmh.mo.gov.

Any forms received after the 25th of the month are not guaranteed to be processed until the next month.

**Part 1**

DD HH Provider:       DD HH Medicaid Provider #:

**Part 2**

Date:       MO HealthNet ID/DCN #:       Date of Birth:

Participant Name:

**Part 3**

Please select reason for discharge:

[ ]  OO – Participant or guardian request for discharge [ ]  PM – Moved

[ ]  NC – Unable to contact participant [ ]  PD – Deceased

[ ]  PI – Participant no longer receives care at DD HH [ ]  MI – Medicaid Inactive or Ineligible

[ ]  SD – Spend Down Not Met 3 or more consecutive months

[ ]  HD – DD HH request for discharge (if different from reasons listed above):

[ ]  PO – Other reason for discharge (if different from reasons listed above):

**Part 4**

**MO HealthNet/DMH USE ONLY:**

Discharge Request: [ ]  Approved [ ]  Denied Date Form Received:

Date Approved/Denied:       Effective Date of Discharge:

Reason Request Denied

Request Processed By