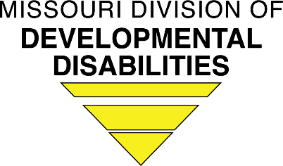
 ****

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](mailto: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