Discharge Form

The CMHC Healthcare Home Discharge Form must be completed in full. Please complete the form, save a copy, and submit the form as an attachment in an **encrypted email** or submit the **password protected** form to CMHCHCH@dmh.mo.gov. Indicate "CMHC HCH DISCHARGE" in the subject line of the email. Any forms received after the 25th of the month are not guaranteed to be processed until the next month.

MISSOURI DEPARTMENT OF MENTAL HEALTH

PART 1

Healthcare Home: _____ HCH Medicaid Provider # _____

PART 2

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

Participant Name: _____
First MI Last

Mailing Address: _____
Street

_____
City State Zip Code

PART 3

Does the participant have a Guardian/Parent? ☐ Yes ☐ No

If yes, Name of Guardian/Parent: _____
First MI Last

Guardian/Parent Address: (if different from participant) _____
Street

_____
City State Zip Code

Has the Guardian/Parent been notified of the discharge? ☐ Yes ☐ No

PART 4

Please select the reason for discharge:

- ☐ OO – Participant or guardian request for discharge
- ☐ NC – Unable to contact participant
- ☐ PI – Participant no longer receives care at HCH
- ☐ SD – Spend Down Not Met 3 or more consecutive months
- ☐ HD – Healthcare Home request for discharge (if different from reasons listed above):

_____

- ☐ PO – Other reason for discharge (if different from reasons listed above):

_____

- ☐ PM - Moved
- ☐ PD - Deceased
- ☐ MI – Medicaid inactive or ineligible

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: _____